

**TERMINATION
OF DEPENDENT
COVERAGE**



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* Use this form if you wish to remove dependents from your Health Plan.

| | |
|---------------|---------------------|
| GROUP NAME | GROUP NO. |
| EMPLOYEE NAME | PACIFCSOURCE ID NO. |

Effective 1/1/2011 (date) I wish to terminate PacificSource group health coverage for my family member(s) listed below:

| NAME - LAST | FIRST | INITIAL | REASON |
|-------------|-------|---------|--------|
| NAME - LAST | FIRST | INITIAL | REASON |
| NAME - LAST | FIRST | INITIAL | REASON |
| NAME - LAST | FIRST | INITIAL | REASON |
| NAME - LAST | FIRST | INITIAL | REASON |

I understand that, should I wish to re-enroll these family members at a later date, they could be subject to waiting periods for coverage.

Employee Signature

Date