



# SCOTT & WHITE HEALTH PLAN

The one Texans trust.

**FOR OFFICE USE ONLY:**

Member Number: \_\_\_\_\_  
Payment Method: ( ) APS ( ) E-PAY ( ) Coupon  
Date Sent: \_\_\_\_\_  
SWHP Representative: \_\_\_\_\_

## Request for Disenrollment of Health Plus Coverage

Please print clearly in ink. Form is to be completed by the contract holder of the Health Plus Plan.

**\*Important: Disenrollment will be effective the last day of the month in which this form is received.\***

Fax: 254-298-3567 Attention: Health Plus

Terminate Entire Contract                       Disenroll only the Member(s) Listed

*Optional riders end when the entire contract is terminated. Members may elect to drop optional riders only during open enrollment and coverage will end for all members on the contract:*

Prescription Drug Plan     MetLife Dental     MetLife Life Insurance

Contract Holder \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

SSN \_\_\_\_\_ Date of Birth \_\_\_\_\_ Email \_\_\_\_\_

**Complete only if disenrolling member(s) from your contract:**

Member's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

\_\_\_\_\_

**Have you decided to go without health insurance?**    Circle Y N

**Please Give Your Reason for Disenrollment:**

- Enrolling in Scott & White Health Plan (SWHP) group plan/other individual plan
- Enrolling in non-SWHP group plan/military/government-assisted plan
- Moving out of the service area
- Premium more affordable with another health plan (please circle below/other)
  - BlueCross    Aetna    Humana    United Healthcare    Cigna    Unicare
  - Other \_\_\_\_\_
- Benefits more attractive with another health plan (please circle below/other)
  - Deductible \$ \_\_\_\_\_ Percent Paid After Deductible    Office Co-pay    Doctor
  - Other \_\_\_\_\_
- Other \_\_\_\_\_

**Note:** Members who request disenrollment may continue to receive medical care from Health Plus providers until the following **disenrollment date:** \_\_\_\_\_

**(Last day of the month in which this form is received by Scott & White Health Plan)**

Contract Holder's Signature \_\_\_\_\_ Date \_\_\_\_\_