

**Scott & White Health Plan**  
**Request for Disenrollment/Termination of the Health Plus Prescription Coverage**

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

**IMPORTANT NOTE : THIS FORM WILL TERM PRESCRIPTION COVERAGE ON ALL MEMBERS OF THIS HEALTH PLUS PLAN.**

<b>Contract Holder:</b>			
Last	First	Middle	
<b>Address:</b>			
Street/P.O. Box	City	State	Zip Code
<b>Telephone:</b>			
Home (    )		Work (    )	
<b>Date of Birth:</b>	<b>Social Security Number:</b>	<b>I.D. Number:</b>	

<b>Reason for Termination:</b>
--------------------------------

Termination Date: \_\_\_\_\_

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

<b>FOR OFFICE USE ONLY</b>	
Date Sent: _____	<input type="checkbox"/> APS <input type="checkbox"/> E-Pay <input type="checkbox"/> Coupon
SWHP Rep: _____	New Rate: _____