

**Scott & White Health Plan**  
**Request for Disenrollment/Termination of the Health Plus Dental 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 dental coverage for all members on 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 #:</b>	<b>Member ID #:</b>	

**Reason for Termination:**

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

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

**FOR OFFICE USE ONLY**

Date Sent: \_\_\_\_\_       APS    E-Pay    Coupon

SWHP Rep: \_\_\_\_\_      New Rate: \_\_\_\_\_