Scott & White Health Plan
Request for Disenrollment/Termination of Life Insurance Coverage for Health Plus

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

IMPORTANT NOTE: THIS FORM WILL TERM LIFE INSURANCE COVERAGE ON ALL MEMBERS ON THIS HEALTH PLAN.

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

Reason for Termination:

Termination Date: ___________________________
(Last day of the month in which form is received by Scott & White Health Plan)

Contract Holder's Signature: __________________________ Date: ____________

FOR OFFICE USE ONLY

Date Sent: ________________ [] **APS** [] **Coupon**

SWHP Rep: _______________ New Rate: ______________