

**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: Terminations will be effective the last day of the month in which it is received.** ←

<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>	

**Note: If you elect to disenroll, it must be on you and all members of your family currently covered on your Health Plus Plan.**

**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: \_\_\_\_\_