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| FOR OFFICE USE ONLY: Member Number: _____ Payment Method: ()APS ()E-PAY ()Coupon Date Sent: _____ SWHP Representative: _____ |
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Request for Disenrollment of Young Texan Coverage

Please print clearly in ink. Form is to be completed by the contract holder of the Young Texan Plan.
Important: Disenrollment will be effective the last day of the month in which this form is received.
Fax: 254-298-3567 Attention: Young Texan

Terminate Entire Contract

Optional riders end when the entire contract is terminated. Members may elect to drop optional riders only during open enrollment:

Prescription Drug Plan **MetLife Dental** **MetLife Life Insurance**

Purchaser/Contract Holder _____
 Address _____
 Home Phone _____ Work Phone _____
 Date of Birth _____ Email _____

Name of Child to be Disenrolled _____
 Address (if different from above) _____
 Child's Social Security Number _____ 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 Young Texan providers until the following **disenrollment date:** _____
(Last day of the month in which this form is received by Scott & White Health Plan)

Purchaser/Contract Holder's Signature _____ Date _____