

**TERMINATION
OF DEPENDENT
COVERAGE**



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GROUP NAME	GROUP NO.
EMPLOYEE NAME	PACIFCSOURCE ID NO.

Effective _____ (date) I wish to terminate PacificSource group health coverage for my family member(s) listed below:

NAME - LAST	FIRST	INITIAL	REASON

I understand that, should I wish to re-enroll these family members at a later date, they could be subject to waiting periods for coverage.

Employee Signature

Date