TERMINATION OF DEPENDENT COVERAGE

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GROUP NAME	GROUP NO.
EMPLOYEE NAME	PACIFICSOURCE ID NO.

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

NAME - LAST	FIRST	INITIAL	REASON
NAME - LAST	FIRST	INITIAL	REASON
NAME - LAST	FIRST	INITIAL	REASON
NAME - LAST	FIRST	INITIAL	REASON
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