415 W 17th Street
Suite 140
Cheyenne, WY 82001
307.634.5566

Request to Cancel Dependent Coverage

YOUR NAME _____ Date cancellation is to become effective _____

SOCIAL SECURITY NUMBER _____ **ID NUMBER** _____

ADDRESS _____ **CITY** _____ STATE _____ ZIP _____

☐ Check here if address is different.

SIGNATURE _____ **DATE SIGNED** _____

NOTE: I have read and understand the evidence of insurability requirements and/or late enrollee limitations of my Group Master Agreement or Plan document and realize that if I decide to add these dependents at a later date, they will be subject to these provisions as permitted by applicable law.

Please check below the relationship of dependent(s):

☐ Husband ☐ Wife ☐ Son ☐ Daughter ☐ Other _____

Reason for deleting dependent(s) from coverage:

☐ Divorce _____ (MM/DD/YYYY) ☐ Separation _____ (MM/DD/YYYY) ☐ Death _____ (MM/DD/YYYY) ☐ Receiving coverage elsewhere

☐ Child no longer eligible for coverage because: ☐ By Request

☐ No longer full-time student (give last date of full time attendance) _____ (MM/DD/YYYY)

☐ Other (please explain) _____

	PRINT FIRST NAME & INITIAL (INCLUDE LAST NAME IF DIFFERENT)	BIRTHDATE (MM/DD/YYYY)
Delete 1.		
Delete 2.		
Delete 3.		
Delete 4.		