

TOTAL PLAN SERVICES, INC.
 14001 Dallas Parkway North * Suite 700 * Dallas, TX 75240
 469-791-5900 * Fax 469-791-5941 * Watts 800-969-5238

REQUEST FOR CANCELLATION OF INSURANCE

Group Name _____ Group # _____

Employee Name _____

Social Security # _____

Date of Cancellation _____

Reason for Cancellation _____

Please check the coverage to be canceled:

	All Coverage	Major Medical	Dental	Life And AD&D	Dep. Life	Short Term Disability	Long Term Disability	Other Coverage
Employee Only								
Spouse Only								
Child(ren) Only								
Spouse And Child(ren)								

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in the plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption. A Late Enrollee will also be required to furnish a Supplemental Enrollment Form.

Employee Signature _____ Date _____

Please submit completed form to your group administrator.