



administered by *Trusteed Plans Service Corporation*
 6901 6th Avenue – Tacoma, WA 98406
 PO Box 1894 – Tacoma, WA 98401
 Fax: 253-564-5881

REQUEST FOR CANCELLATION

Please print in black or blue ink. Incomplete and/or illegible information may result in delayed processing. The form must be signed and dated by the Authorized Group Administrator or it will be returned.

SECTION 1 – GROUP INFORMATION				Telephone Number		
Group Number	Group Name					
SECTION 2 – EMPLOYEE AND DEPENDENT CANCELLATION INFORMATION						
Please complete each section below to remove an employee or his/her dependent(s) from coverage.						
Employee or Dependent Name	Date of Birth	Reason	Effective Date	Enter the last date of coverage for this member.	Check below if employee paid no premium for coverage after the cancellation effective date.	Check below to verify that the employee does not (or did not) have an expectation of coverage after the cancellation effective date.
1.					<input type="checkbox"/>	<input type="checkbox"/>
2.					<input type="checkbox"/>	<input type="checkbox"/>
3.					<input type="checkbox"/>	<input type="checkbox"/>
4.					<input type="checkbox"/>	<input type="checkbox"/>
5.					<input type="checkbox"/>	<input type="checkbox"/>
6.					<input type="checkbox"/>	<input type="checkbox"/>
SECTION 3 – AUTHORIZED SIGNATURE						
Print Name of Authorized Group Administrator			Signature of Authorized Group Administrator		Date	

*For each person listed, both boxes must be checked in order to cancel coverage as of an effective date prior to the date that this form is received. If both boxes are not checked, coverage will be cancelled as of the last day of the month during which the form is received.

Return this form to: Trusteed Plans Service Corporation | PO Box 1894 | Tacoma, WA 98401

Asuris Northwest Health 1800 9th Ave PO Box 21267 Seattle, WA 98111-3267