Dependent Deletion Form

Fill out completely by typing or printing in ink

Name of Member:_____

Member's Subscriber/ Member ID Number: _____

Home Address:_____

Number and Street City State Zip

DEPENDENT('S) FULL NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER	RELATIONSHIP

If any of the above listed dependents do not reside with you, provide address:_____

_____

Effective Date of Change:_____

Qualifying Event (Reason):_____

(Requests must be made within 60 days of a Qualifying Event to be eligible for COBRA.)

_____ (initial) **I certify that the above information is true and correct. I understand that in deleting the above listed dependent(s), I may not add the dependent(s) back on my policy unless a Qualifying Event occurs or during Open Enrollment in the month of November.**

_____ **(initial)** **Deleting dependent(s) for any reason other than a Qualifying Event is deemed a voluntary cancellation of coverage. Voluntary cancellation is not considered a Qualifying Event for continuation of coverage under COBRA rights. Refer to your Summary Plan Description for a list of all Qualifying Events.**

_____ _____

Signature of Member Date

NOTE: This information needs to be received in our office in a timely manner. We do not accept faxes. All parts of this form must be completed to assure validity and to update eligibility. Please send completed forms to Wisconsin Health Fund, 1314 N Stoughton Rd, Madison, WI 53714. If you have any questions regarding this form, call WHF Customer Service at 1-888-208-8808.