SOUTHWEST HEALTH BENEFITS FUND

Fund Office
8441 Gulf Freeway
Suite 304
Houston, Texas 77017-5066
Phone: 713-643-9300
Fax: 866-316-4794
Toll Free: 866-236-3148

Date: _____

I request, _____, be removed from medical
(NAME OF PERSON BEING REMOVED FROM INSURANCE)

benefits provided by the **Southwest Health Benefits Fund** as of _____
(DATE OF TERMINATION)

due to:

- ☐ Coverage with another private insurance provider
- ☐ Coverage with Medicare/Medicaid
- ☐ Qualifying Life Event (marriage/divorce/birth of child)

*******Documentation must be provided*******

I, _____, understand that by submitting this
(NAME OF PRIMARY INSURED)

request, the above individual will no longer be covered under medical benefits provided by the **Southwest Health Benefits Fund** and is not eligible for coverage unless there is a qualifying event or I choose to re-enroll them during open enrollment.

_____
SIGNATURE OF PRIMARY INSURED

_____
SOCIAL SECURITY NUMBER OF PRIMARY INSURED