



Asuris Northwest Health  
 1800 Ninth Avenue  
 PO Box 91130  
 Seattle, Washington 98111

### 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

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.

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 have an expectation of coverage after the cancellation effective date.

Employee or Dependent Name	Date of Birth	Reason	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 for Asuris Northwest Health to cancel coverage with an effective date prior to the date that Asuris Northwest Health receives this form. If both boxes are not checked, Asuris Northwest Health will cancel coverage effective the last day of the month in which this form is received.

**Return this form to the Membership Administrator or Membership Administrative Team indicated on your bill.**