REQUEST TO DROP DEPENDENTS

Effective Date: _____

Employee Name (Please Print):_____

Dependents to Drop: _____

Coverages to Drop: _____

Is dependent being dropped due to:

divorce,	[ ] no	[ ] yes
legal separation,	[ ] no	[ ] yes
dependent ceasing to be a dependent, or	[ ] no	[ ] yes
death	[ ] no	[ ] yes

If yes, dependent may be eligible for COBRA continuation benefits.

_____ _____

Name Date