WAYNE STATE UNIVERSITY

For the Total Compensation and Wellness Department use only
Effective Date:

Medical Plan Termination Form

To Delete a Dependent/Subscriber

Please print all information.

This form must be received in the Total Compensation and Wellness Department within 30 days of the date of event (date of divorce, loss of dependency, etc.). If the form is received beyond the 30-day period, or is received incomplete, premiums will not be refunded.

You must include the current address of the dependent for the form to be considered complete. The Total Compensation and Wellness Department will not process the form if it is not complete.

Subscriber Information

Social Security Number	Customer ID	Last Name	First Name	Middle I

1. Person to be Deleted (If subscriber terminates, all dependents terminate automatically)

Social Security Number	Last Name	First Name	Middle Name

Address and Street	Zip Code	City and State	Birth Date

Reason for deleting person (other coverage, divorce, loss of dependency, death, etc.)	Date of event (divorce, other coverage, etc.)

2. Person to be Deleted

Social Security Number	Last Name	First Name	Middle Name

Address and Street	Zip Code	City and State	Birth Date

Reason for deleting person (other coverage, divorce, loss of dependency, death, etc.)	Date of event (divorce, other coverage, etc.)

3. Person to be Deleted

Social Security Number	Last Name	First Name	Middle Name

Address and Street	Zip Code	City and State	Birth Date

Reason for deleting person (other coverage, divorce, loss of dependency, death, etc.)	Date of event (divorce, other coverage, etc.)

The information listed above is correct to the best of my knowledge.

I authorize the release of the information listed above to the insurance plan I have selected for the purpose of obtaining coverage. The information will be provided to the insurance plan in electronic format.

Signature	Date Signed