

## Writers' Guild-Industry Health Fund

## **DEPENDENT DISENROLLMENT FORM**

	nroll a dependent from your plan, this form nee Fund Office at the address below. Please i		•
	DIVORCE or ANULLMENT*		A copy of the divorce decree
	OTHER EVENT: (Coverage no longer desired, term	n of Foster relationship, etc.)	Applicable documentation if available
Participant Name		mber	
	PLEASE LIST EACH DEPENDENT	ГО BE REMOVED FROM YC	OUR PLAN
First Name	Last Name	Relationship	Disenrollment Reason
First Name	Last Name	Relationship	Disenrollment Reason
First Name	Last Name	Relationship	Disenrollment Reason
First Name	Last Name	Relationship	Disenrollment Reason
* Please provide ma	ailing address and telephone number for your ex-spou	se for COBRA notification purpose	es.
Ex-Spouse's Address	City	State	Zip Code
-mail Address		Phone Number	