Electrical Medical Trust

8441 GULF FREEWAY, STE 304
HOUSTON TX 77017
PH: 713-643-9300 ◆ FX: 1-866-316-4794

Date: _____

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

benefits provided by the **ELECTRICAL MEDICAL** TRUST 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)

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

Request, the above individual will no longer will be covered under medical benefits provided by **ELECTRICAL MEDICAL TRUST** 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

*** A Certificate of Credible Coverage will be mailed out indicating what dates your dependent(s) were covered under our plan. You should expect to receive this within 2 weeks from the date you notified our office.**