Johnson City Schools
Health/Dental Termination of Coverage

Employee Name (Last, First, Middle Initial): _____

Social Security Number:_____ Date of Birth: _____

__Male __Female

Address:_____

I wish to terminate coverage effective _____ for the following:

Employee_____ Date of Birth_____ Social Security #_____

Dependent_____ Date of Birth_____ Social Security #_____

Dependent_____ Date of Birth_____ Social Security #_____

Dependent_____ Date of Birth_____ Social Security #_____

****I understand that I am requesting that the coverage on the person(s) listed above will terminate on the effective date listed.**

X_____

****A scanned, imaged or photocopied version of this completely executed form will have the same force and effect as the original document.**