



# CANCELLATION FORM

<input type="checkbox"/> <b>Member Information</b>	<b>First Name</b>	<b>Last Name</b>
<b>Member ID #</b>  <b>#ZGR</b>	<b>Telephone Number</b>	
<input type="checkbox"/> <b>Cancellation of Coverage</b>  If cancellation of coverage applies to other covered family members, attach a separate page listing the name and Pool Member ID # for each family member.	<b>Cancellation Effective Date:</b>  <b>I wish to cancel my Pool coverage. My reason for cancellation is:</b>	
<b>Signature of Member</b>  <b>X</b>	<b>Date</b>	<b>Signature of Parent or Legal Guardian</b> (If Member is under age 18 or legally incompetent)  <b>X</b>

Mail this form to: Texas Health Insurance Pool  
 P. O. Box 660819  
 Dallas, TX 75266

Fax this form to: 1-325-793-4134  
 Questions? Call: 1-888-398-3927  
 Web site: www.txhealthpool.org