North Central States Regional Council of Carpenters' Health Fund

Adult Child Coverage Cancellation Form

Participant Name _____
(Please print full name clearly)

Participant Address _____

Participant Identification Number _____

Effective Date of Cancellation_____

Please complete this section to remove adult children from your Health Plan coverage:

_____	_____
Print Child Name	**Print Date of Birth**
_____	_____
Print Child Name	**Print Date of Birth**
_____	_____
Print Child Name	**Print Date of Birth**
_____	_____
Print Child Name	**Print Date of Birth**

I understand that the children listed above will not be covered under the North Central States Regional Council of Carpenters' Health Fund.

Participant's Signature _____

Date _____