INSURED'S REQUEST TO TERMINATE ENROLLMENT IN TEXAS HEALTH CARE NETWORK

First Named Insured _____ Policy Number _____

I request to terminate participation in Acuity's Texas certified workers' compensation health care network as of the termination date shown below.

I understand my workers' compensation policy will no longer be eligible for a certified health care network discount as of the termination date shown below.

_____	_____	_____
Named Insured's Signature	Employer	Termination Date

_____	_____
Named Insured's Printed Name	Date Signed

Please mail this completed document to:

Acuity, A Mutual Insurance Company
Underwriting Department
2800 South Taylor Drive
Sheboygan, WI 53081