



Human Resources
Employee Benefits and Services

Retiree Medical/Dental Plan Cancellation

FOR OFFICE USE ONLY			
Effective Date	Month	Day	Year
Group #			
Employee ID #			

A I CHOOSE TO CANCEL THE FOLLOWING MEDICAL AND/OR DENTAL COVERAGE							
Plan Name	Effective Date of Cancellation (must be 1st of the month)						
Medical:	<table border="1"> <tr> <td>Month</td> <td>Day</td> <td>Year</td> </tr> <tr> <td></td> <td>1</td> <td></td> </tr> </table>	Month	Day	Year		1	
Month	Day	Year					
	1						
Dental:	<table border="1"> <tr> <td>Month</td> <td>Day</td> <td>Year</td> </tr> <tr> <td></td> <td>1</td> <td></td> </tr> </table>	Month	Day	Year		1	
Month	Day	Year					
	1						

B RETIREE INFORMATION			
Social Security No.	Check One <input type="checkbox"/> Male <input type="checkbox"/> Female	Date Of Birth Month Day Year	Check One <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partner
Last Name	First Name	MI	For Name Change, List Former Name Here
Mailing Address	Check Here If New Address <input type="checkbox"/>		Home Phone () Alternate Phone ()
City	State	Zip Code	

C DEPENDENT INFORMATION (enrolled in a retiree plan)			
Last Name, First Name	Social Security #	Enrolled in Dental	Enrolled in Medical—Plan name if different from above
Spouse/Domestic Partner:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No Plan Name:
Children:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No Plan Name:
Children:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No Plan Name:
Children:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No Plan Name:
Children:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No Plan Name:
Children:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No Plan Name:

Subscriber's Signature _____

Date _____