



## Request to Cancel Coverage

Name \_\_\_\_\_ SSN \_\_\_\_\_

Address \_\_\_\_\_ Provider # \_\_\_\_\_

City, State Zip \_\_\_\_\_

Telephone \_\_\_\_\_

Please cancel my:  Medical and Dental Coverage effective \_\_\_\_/\_\_\_\_/\_\_\_\_

Dental Only Coverage effective \_\_\_\_/\_\_\_\_/\_\_\_\_

Please cancel my spouse/dependent:

*(If canceling spouse insurance your spouse must sign below.)*

Medical and Dental Coverage effective \_\_\_\_/\_\_\_\_/\_\_\_\_

Dental Only Coverage effective \_\_\_\_/\_\_\_\_/\_\_\_\_

Note: You cannot cancel Medical and keep Dental insurance only.

### Reason for Cancellation

Enrolled in another group health plan Plan Name \_\_\_\_\_

Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Group Number \_\_\_\_\_

Other (please describe)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Spouse Signature

\_\_\_\_\_  
Date