

Health and Welfare  
Coverage Discontinuation Form

\_\_\_\_\_  
Employee Name

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Telephone Number

I wish to discontinue the following Health and Welfare coverage: (please check)

- Medical    Name of plan: \_\_\_\_\_
- Dental    \_\_\_\_\_ Delta Dental PPO    \_\_\_\_\_ DeltaCare HMO
- Vision    VSP Vision Service Plan
- Life    Mutual of Omaha
- Other    Please specify: \_\_\_\_\_

Please remove the following persons from the above specified coverages:

- Myself    Name : \_\_\_\_\_
- Spouse    Name : \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_
- Child    Name : \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_
- Child    Name : \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_
- Child    Name : \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

**Please terminate coverage effective:** \_\_\_\_\_

By signing this request, I understand that I cannot re-enroll into the above indicated coverages until the next open enrollment period. The only exception would be if I were to have qualifying event occur such as marriage, birth, loss of coverage etc. in which case, I would have 60 days from the date of the qualifying event to notify the benefits department in writing of my request to re-enroll.

\_\_\_\_\_  
Signature of Employee

\_\_\_\_\_  
Date

\_\_\_\_\_  
District Approval

\_\_\_\_\_  
Date

Internal Office Use Only:

HRS: \_\_\_\_\_ CalPERS: \_\_\_\_\_ Delta: \_\_\_\_\_ VSP: \_\_\_\_\_ Other: \_\_\_\_\_