



RETIREE DENTAL CANCELLATION FORM

NAME: _____ SSN: _____

DENTAL PLAN:	☐ CORE	☐ BUY-UP
COVERAGE TIER:	☐ RETIREE ONLY	☐ FAMILY

Cancellation Date: _____

Final Coverage Date: _____

I understand that this is a formal request to terminate my dental coverage with the PSJA Dental Retiree Program. I further understand that I will no longer have coverage as of the "Final coverage date" and all charges associated with premiums will no longer be deducted from the account provided.

SIGNATURE _____

DATE _____

START COLLEGE NOW! COMPLETE EARLY! GO FAR!

601 E. Kelly St., Pharr, TX 78577 P: (956) 354-2029 www.psjaisd.us

It is the policy of Pharr-San Juan-Alamo ISD not to discriminate on the basis of sex, disability, race, color, religion, national origin or age.