CONEJO VALLEY UNIFIED SCHOOL DISTRICT
BUSINESS SERVICES DEPARTMENT
750 Mitchell Road, Newbury Park, CA 91320

HEALTH BENEFIT TERMINATION REQUEST

Employee Legal Name _____ _____ _____
LAST FIRST MIDDLE

Social Security # XXX –XX- _____

Employee Contact
_____ _____
EMAIL PHONE #

INSTRUCTIONS: PLEASE SPECIFY THE PERSONS FOR WHOM YOU ARE REQUESTING COVERAGE TERMINATION.

MEMBER FULL NAME (YOURSELF OR DEPENDENT)	CHECK ALL COVERAGE TO TERMINATE	EFFECTIVE DATE
	☐ ANTHEM PPO ☐ KAISER HMO ☐ VSP-VISION ☐ DENTAL	
	☐ ANTHEM PPO ☐ KAISER HMO ☐ VSP-VISION ☐ DENTAL	
	☐ ANTHEM PPO ☐ KAISER HMO ☐ VSP-VISION ☐ DENTAL	
	☐ ANTHEM PPO ☐ KAISER HMO ☐ VSP-VISION ☐ DENTAL	
	☐ ANTHEM PPO ☐ KAISER HMO ☐ VSP-VISION ☐ DENTAL	

BASIS FOR COVERAGE TERMINATION

☐ Alternate Health Plan
☐ Enrolled in Medicare
☐ Moved out of service area
☐ Member deceased
☐ Other

CERTIFICATION

I, _____, am authorizing the above specified changes to my enrollment AND/OR to that of my dependents.

_____ _____
Signature Date

TRANSMIT TO:

Mail/In-Person - 750 Mitchell Road, Newbury Park CA 91320
Conejo Valley Unified School District
Employee Health Benefits Specialist - Mia Nelson
Email to Specialist at: mnelson@conejousd.org

BENEFITS DEPARTMENT USE ONLY

Termination coverage request received on: _____

Coverage terminated as of: _____

Processed by: _____