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: _____