CANCELLATION NOTICE FOR SELF-PAY
HEALTH AND LIFE INSURANCE

Employee/Retiree Name: ________________________________

Employee/Retiree ID#: _______________________________

I would like to discontinue the following insurance plan(s) effective _______________.

(Effective Date)

PLEASE NOTE: Termination will be effective on the first day of the month following the date this form is received by the Employee Benefits Department. Retro-active termination requests of medical plans will only be considered with proof of enrollment into other insurance coverage (Non-Medicare plans).

☐ Medical* ☐ Hartford Supplemental Life Insurance
☐ Dental ☐ Hartford Spousal Life Insurance
☐ Vision ☐ Hartford Dependent Life Insurance
☐ Prudential AD&D Insurance
☐ American Fidelity:
☐ Life ☐ Disability
☐ Cancer ☐ Accident Only

*MEDICARE GROUP PLAN MEMBERS:
To cancel your plan, the Center for Medicare & Medicaid Services (“CMS”) requires written notification. Medicare group plans cannot be retro-actively terminated. You are responsible for all premiums through the month of the plan cancellation. To comply with Federal guidelines, it may take up to two months to cancel a plan. Please contact the Employee Benefits Department for more information (619) 725-8130.

Please mail or take this form to the following address:

Employee Benefits Department
4100 Normal St. Room 1150-A
San Diego, CA 92103

You can also fax this request to: 619.725.8132

Please call with any questions 619.725.8130, our office is open Monday through Friday from 8:00 a.m. to 5:00 p.m.

__________________________________________  _________________
Signature                                      Date

Eugene Brucker Education Center::4100 Normal St., Rm. 1150A::San Diego, CA  92103-2682::www.sandi.net