



RETIREE MEDICAL AND/OR DENTAL PLAN CANCELLATION FORM

San Bernardino County
Employee Benefits and Services Division (EBSB)
157 West Fifth Street, First Floor
San Bernardino, CA 92415-0440
(909) 387-5787 Fax (909) 387-5566

Effective Date	Month	Day	Year
Group #			
Employee ID #			

A I CHOOSE TO CANCEL MY MEDICAL AND/OR DENTAL COVERAGE

Medical plan name _____

Delta Dental PPO

B RETIREE INFORMATION

1. Social Security No.		2. Check One: <input type="checkbox"/> Male <input type="checkbox"/> Female		3. Date Of Birth Month Day Year		4. Check One: <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partner	
5. Last Name		6. First Name		7. MI	8. For Name Change, List Former Name Here		
9. Mailing Address _____ Check Here If New Address <input type="checkbox"/>				10. Home Phone () Work Phone ()			
11. City		12. State	13. Zip Code				

Subscriber's Signature _____

Date _____

RETURN FORM TO:

San Bernardino County
Employee Benefits and Services Division (EBSD)
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