



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

<i>FOR OFFICE USE ONLY</i>			
Effective Date	Month	Day	Year
Group #.			
Employee ID #			

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

Medical plan name _____

Dental plan name _____

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 ()
11. City			Alternate Phone ()
12. State		13. Zip Code	

Subscriber's Signature _____

Date _____

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FORMS

RETURN FORM TO:

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