RETIREE GROUP HEALTH PLAN

INSURANCE CANCELLATION REQUEST

Retiree Name: _____ Telephone Number: _____ ID: _____

Address: _____ City: _____State: _____ Zip: _____

Please cancel the following insurance coverage(s):

_____Retiree Medical Insurance

_____Dependent Medical Insurance

Dependent Name: _____

_____Retiree Dental Insurance

_____Dependent Dental Insurance

Dependent Name: _____

_____Retiree Life Insurance

To be effective on: _____ (The earliest indicated coverage can be cancelled is at the end of the month in which this request is received in our office. Premiums must be paid through the cancellation date.)

NOTE: ALL CANCELLATIONS ARE IRREVOCABLE (Once cancelled, coverage will not be reinstated.)

_____ _____

Signature Date

Please sign, date, and mail or fax this form to:

Miami-Dade County

Benefits Administration

111 NW 1st Street, Suite 2340

Miami, FL 33128-1979

Fax: 305-375-1633 or 305-375-1368