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 Coverage

☐ Dependent(s) _____ Medical Insurance Coverage
Name(s)

☐ Retiree Dental Insurance

☐ Dependent(s) _____ Dental Insurance Coverage
Name(s)

☐ Retiree Vision Insurance

☐ Dependent(s) _____ Vision Insurance Coverage
Name(s)

☐ 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.)

By signing this form, I acknowledge that 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 2324
Miami, FL 33128-1979
Fax: 305-375-1368