RIVCO HR benefits division

REQUEST TO CANCEL RETIREE HEALTH CARE BENEFITS

INSTRUCTIONS: Complete and submit this form to Human Resources Benefits to cancel your participation and/or your dependent's participation in your County retiree health care plan(s).

IMPORTANT: If you cancel your participation and/or your dependent's participation in your health care plan(s), you can re-enroll ONLY during the annual enrollment period or if you experience a qualified change in status. See the Retiree Annual Enrollment Guide (available at http://benefits.rc-hr.com) for information on making mid-year changes to your health care plan.

CANCELLATION EFFECTIVE DATE: Cancellations will take effect on the first day of the month following Human Resources Benefits' receipt of this form OR at a **future** date if indicated below.

RETIREE INFORMATION

Name of Retiree:	Retiree Record #:	Contact Phone:	
Street Address:	City:	State:	Zip:

RETIREE/DEPENDENTS TO BE CANCELLED

List the dependent(s) to be cancelled from your County retiree health care plan(s), along with the specific heath plan and the cancellation effective date. If you elect to cancel participation in a Dental or Vision Plan, all dependents will also be cancelled.

Cancel Retiree and ALL Dependents? ☐ Yes ☐ No		Cancel Dental? ☐ Yes ☐ No	Cancel Vision? ☐ Yes ☐ No	Effective Date:
Name of Dependent:	Date of Birth:	Cancel Dental? ☐ Yes ☐ No	Cancel Vision? ☐ Yes ☐ No	Effective Date:
Name of Dependent:	Date of Birth:	Cancel Dental? ☐ Yes ☐ No	Cancel Vision? ☐ Yes ☐ No	Effective Date:
Name of Dependent:	Date of Birth:	Cancel Dental? ☐ Yes ☐ No	Cancel Vision? ☐ Yes ☐ No	Effective Date:
Name of Dependent:	Date of Birth:	Cancel Dental? ☐ Yes ☐ No	Cancel Vision? ☐ Yes ☐ No	Effective Date:

I request that my participation and/or my dependent's participation in my County retiree health care plan(s) be cancelled as indicated on this Request to Cancel form.

______________________________ ______________________

Retiree Signature *(required)* **Date *(required)***

Submit this form to: Human Resources Benefits, 4080 Lemon St, PO Box 1569, Riverside, CA 92502-1569. This form can also be faxed to (951) 955-3490. For assistance, contact the Benefits Line at (951) 955-4981.