RETIREE HEALTH CANCELLATION FORM

Please use this form if you would like to cancel your coverage or dependent coverage on the Retiree Plan offered by the UCM Benefits Group through Blue Cross Blue Shield. NOTE: If the Retiree coverage is terminated, all dependants of retirees will be termed as well.

SECTION 1: Participant Identification

Participant Name: _____

Participant SSN: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Are you terminating your own coverage? _____Yes _____ No

SECTION 2: Termination Information

List below all individuals for whom you are terminating coverage:

Name	Social Security #	Relationship	Term Date*

*Termination date must be the last day of month.
*Services incurred after the termination date will be denied.

SECTION 3: Signature

I hereby certify, by my signature, if a retiree terminates participation in the Plan, such covered persons may not become a covered person there after.

Print Name: _____Signature: _____ Date: _____

BY MAIL:
Office of Human Resources
Retiree Benefits
101 Administration Bldg
Warrensburg, MO 64093

BY FAX:
660-543-4200