

Medical / Dental Coverage Cancellation

Check all that apply:

Medical Coverage:

- Retiree
- Spouse / Domestic Partner
- Dependant(s)

Please provide name(s) of dependant(s)

Dental Coverage:

- Retiree
- Spouse / Domestic Partner
- Dependant(s)

Please provide name(s) of dependant(s)

I hereby request that the above coverage is cancelled effective ____/____/____.

I understand that by canceling medical and/or dental coverage at this time, I will not have the option of re-enrolling in the group plan.

Print Name

Signature

Date

Seattle City Employees' Retirement System

720 3rd Ave., Suite 900, Seattle, WA, 98104 Telephone: (206)386-1293, Fax: (206)386-1506