Idaho AGC
HEALTH PLAN

CANCELATION REQUEST - EMPLOYEE/DEPENDENT

(Used when an employee is removing self or dependents from coverage while remaining an **active** employee)

Employer Name: ______________________________________ Group Number: ______________________

Employee Name: ______________________________________ SSN: __XXX-XX-_______________________

I, ____, request cancelation of coverage, for the individuals
(Employee Name)

listed below, from the Idaho AGC Health Plan, the last day of _______________, 20________ at Midnight.
(Month) (Year)

Reason for cancellation (required):____

Coverage cancelations outside the plans Open Enrollment period require proof of a life event occurring within 30 days of the requested date of cancelation. Examples of documents are divorce decree or legal separation filed court documents, or proof of other qualified coverage.

1.____________________________________ SSN: xxx-xx-___________________

2.____________________________________ SSN: xxx-xx-___________________

3.____________________________________ SSN: xxx-xx-___________________

4.____________________________________ SSN: xxx-xx-___________________

Employee Signature: ______________________________________ Date: ___________________________

Spouse Signature: ______________________________________ Date: ____________________________

In the case of divorce or separation, update the address for spouse or employee, if either is changing. This ensures COBRA notifications reach the correct individual, for COBRA eligible groups. Employee and spouse are responsible to notify the group of divorce final date if canceling coverage due to legal separation.

Address Update for: ☐ Employee or ____

☐ Spouse ____

**Consult with your employer regarding the dates that changes can be made for Open Enrollment. Cancelations made during Open Enrollment do not require proof of a qualifying life event.*