Idaho AGC HEALTH PLAN

CANCELLATION REQUEST - EMPLOYEE/DEPENDENT

(To be used by the employee when removing self or dependents while remaining an **active** employee)

Employer Name: _____ Group Number:_____

Employee Name: _____ SSN: _____

I, _____, request that the following persons be cancelled
(Employee Name)

from the Idaho AGC Health Plan on the last day of the month of _____, 20_____ at Midnight.
(Month) (Year)

Reason for cancellation (required):_____

_____

_____

(Divorce: provide the date the divorce is final. If requested cancellation date is prior to divorce finalization the spouse being cancelled must sign).

Individuals cancelling coverage:

1._____ SSN: xxx-xx-_____

2._____ SSN: xxx-xx-_____

3._____ SSN: xxx-xx-_____

4._____ SSN: xxx-xx-_____

5._____ SSN: xxx-xx-_____

6._____ SSN: xxx-xx-_____

Employee Signature:_____ Date: _____

Spouse Signature:_____ Date: _____