Idaho AGC HEALTH PLAN

CANCELLATION REQUEST - EMPLOYEE/DEPENDENT

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

Employer Name: _____ Group Number:_____

Employee Name: _____ Last 4 of SSN: 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-_____

5._____ SSN: xxx-xx-_____

6._____ SSN: xxx-xx-_____

☐ I am canceling medical coverage for myself. I wish to retain the group life coverage, and any previously elected voluntary life coverages. I understand I am no longer eligible for group or voluntary Short-Term Disability *(this applies only when employee is canceling coverage for themselves)*.

Employee Signature:_____ Date: _____

In the case of divorce or separation, update the address for spouse or employee, if either is changing. Address Update for:

Employee or _____

Spouse _____