

DELETION(S): Please delete the following person(s) from enrollment/s indicated:

Health Dental Vision (x this box if you wish to delete all family members.)

Reason for Deletion(s) of individual from my enrollment: (Please check one of the following listed below)

DEPENDENT(S) NAME	SOCIAL SECURTY #	RELATIONSHIP	BIRTHDATE

- Obtained non-CSU/alternative insurance coverage: Effective date ____/____/____
- Enroll as State Employee: Date Coverage begins: ____/____/____
- Entering Military Service: Date Coverage begins: ____/____/____
- **Divorce: Date of final decree ____/____/____ **NOTE: Copy of divorce is mandatory. COBRA qualifying event.**
- **Termination of Domestic partnership: Date of Termination ____/____/____ **NOTE: Copy of the Notice of Termination of Domestic Partnership (See Secretary of State) is mandatory. COBRA qualifying event.**
- Enrolls as dependent of State employee: Date coverage begins ____/____/____
- Death: Date of death: ____/____/____
- Change of custody: Date of custody change ____/____/____ **Marriage: Date of marriage ____/____/____
- Over 18 years of age: Date of 18th birthday ____/____/____ **Over 23 years of age: Date of 23rd birthday ____/____/____
- Moves out of Household: **NOTE: COBRA qualifying event.**

****NOTE: Please list ex-spouse's/ex-domestic partner's address, city, state, zip here:**

(Address)

(City)

(State)

(Zip)

CANCELLATION OF ENROLLMENT(S) AND RE-ENROLLMENT(S)

- I elect to cancel my Health Dental **AND ENROLL IN** Flex-Cash
- I elect to enroll in Health Dental **AND CANCEL MY** Flex-Cash
 Health Plan _____ Primary Care M.D. _____
 Dental Plan _____
- I elect to re-enroll in my former health plan: _____ (Name of health plan)
 due to loss of alternative coverage or significant change in alternative coverage.

NOTE: Requires completion of health/dental/flex-cash enrollment forms. I understand that I may change my enrollment during the annual open enrollment period, or based on an eligible family status change.

I certify that all information on this form is complete and true to the best of my knowledge and belief.

Employee Signature Here

Date

Department

Home #

Office Extension #