For Department use only

Medical Plan Termination Form
For Retiree/Surviving Spouse/Eligible LTD Recipients
To Delete a Dependent/Subscriber

Please print all information.

This form must be received in the HR Service Center within 30 days of the date of event (date of divorce, loss of dependency, etc.). If the form is received beyond the 30-day period, or is received incomplete, premiums will not be refunded.

You must include the current address of the dependent for the form to be considered complete. The HR Service Center will not process the form if it is not complete.

Subscriber Information

Last Name	First Name	Middle Initial	Social Security Number	Banner ID

1. Person to be Deleted (If subscriber terminates, all dependents terminate automatically)

Last Name	First Name	Middle Name	Social Security Number

Street Address	Zip Code	City and State	Birth Date

Reason for deleting person (other coverage, divorce, loss of dependency, death, etc.)	Date of event (divorce, other coverage, etc.)

2. Person to be Deleted

Last Name	First Name	Middle Name	Social Security Number

Street Address	Zip Code	City and State	Birth Date

Reason for deleting person (other coverage, divorce, loss of dependency, death, etc.)	Date of event (divorce, other coverage, etc.)

3. Person to be Deleted

Last Name	First Name	Middle Name	Social Security Number

Street Address	Zip Code	City and State	Birth Date

Reason for deleting person (other coverage, divorce, loss of dependency, death, etc.)	Date of event (divorce, other coverage, etc.)

The information listed above is correct to the best of my knowledge.

I authorize the release of the information listed above to the insurance plan I have selected for the purpose of obtaining coverage. The information will be provided to the insurance plan in electronic format.

Signature	Date