Medical Plan Termination Form

Retirees, Surviving Spouses & LTD Recipients

To Terminate Coverage or Delete a Dependent

This form may be completed at any time, however, re-enrollment may be subject to the annual Open Enrollment period guidelines.

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

Retiree/Surviving Spouse/LTD Recipient Information

Name (Last, First) *Please print* | Banner ID | Social Security Number | Date of Birth

Street Address | City | State & Zip Code | County

1. Person to be Deleted (If you terminate your enrollment, all dependents terminate automatically)

First Name *Please print* | Last Name | Social Security Number | Date of Birth

Street Address | City | State & Zip Code | County

Reason for Deletion (other coverage, divorce, death, etc.) | Date of Event (other coverage, divorce, etc.)

2. Person to be Deleted

First Name *Please print* | Last Name | Social Security Number | Date of Birth

Street Address | City | State & Zip Code | County

Reason for Deletion (other coverage, divorce, death, etc.) | Date of Event (other coverage, divorce, etc.)

3. Person to be Deleted

First Name *Please print* | Last Name | Social Security Number | Date of Birth

Street Address | City | State & Zip Code | County

Reason for Deletion (other coverage, divorce, death, etc.) | Date of Event (other coverage, divorce, 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 changing coverage. The information will be provided to the insurance plan in electronic format.

Signature | Date

Return to:
HR Service Center, 5700 Cass Ave., Suite 3638, Detroit, MI 48202; Fax: 313-577-0637; E-mail: askhr@wayne.edu. Use your WSU E-mail and include "#SECURE" in the subject line to ensure your personal information is encrypted.