



REQUEST TO DELETE DEPENDENTS BCBS MEDICAL AND DENTAL POLICY

Name _____ SS# _____

I am requesting that the following dependent(s) be removed from my Blue Cross Blue Shield **medical** **dental policy** Effective date: _____
Request to change policy will be implemented at the beginning of the next month.
Form must be received in the Benefits office at least ten (10) days before the end of the month.

Please provide the following information on the dependent that you would like to have terminated from the policy:

(Address is required in order to forward COBRA insurance information)

1. Name: _____ SS# _____
Address: _____
Date of Birth _____ Relationship to you _____
Reason for termination _____

2. Name: _____ SS# _____
Address: _____
Date of Birth _____ Relationship to you _____
Reason for termination _____

Employee's Signature _____ **Date** _____

Please note that open enrollment is during August, September and October of every year. You will not be able to add family members back to your plan outside of open enrollment unless you have experienced a change in family status or loss/change of other insurance.

By deleting the above dependent(s) from my coverage, my plan now becomes:

MEDICAL

DENTAL

Single

Single

Two Party

Two Party

No Change still Family

No Change still Family

Date Received in Benefits Office _____ Date changed in MUNIS _____

Date notification sent to BCBS _____ Date Cobra filed _____

Please return form to the Benefits Office 920-7919 or 920-7810