SAN BERNARDINO COUNTY

Human Resources
Employee Benefits and Services

For Office Use Only		
Effective Month Date	Day	Year
Group #		
Plan/Class ID # (Blue Shield Only)		
Emp ID #		

County of San Bernardino
Employee Benefits and Services Division (EBSD)
175 West Fifth Street, First Floor
San Bernardino, CA 92415-0440
(909) 387-5787 Fax (909) 387-5566

RETIREE MEDICAL AND/OR DENTAL PLAN CANCELLATION FORM

A I CHOOSE TO CANCEL THE FOLLOWING MEDICAL AND/OR DENTAL COVERAGE

Plan Name	Effective Date of Cancellation (must be 1st of the month)		
	Month	Day	Year
Medical:		1	
Dental:		1	

B RETIREE INFORMATION

Social Security No.	Check One ❑ Male ❑ Female	Date Of Birth Month Day Year	Check One ❑ Married ❑ Widowed ❑ Single ❑ Divorced ❑ Domestic Partner
Last Name / First Name / MI		For Name Change, List Former Name Here	
Mailing Address — Check Here If New Address ❑		Primary Phone ( ) Alternate Phone ( )	
City / State / Zip Code		Email Address	

C DEPENDENT INFORMATION (enrolled in a retiree plan)

Last Name, First Name	Social Security #	Enrolled in Dental	Enrolled in Medical	Plan name if different from above
Spouse/Domestic Partner:		❑ Yes ❑ No	❑ Yes ❑ No	Plan Name:
Children:		❑ Yes ❑ No	❑ Yes ❑ No	Plan Name:
Children:		❑ Yes ❑ No	❑ Yes ❑ No	Plan Name:
Children:		❑ Yes ❑ No	❑ Yes ❑ No	Plan Name:
Children:		❑ Yes ❑ No	❑ Yes ❑ No	Plan Name:
Children:		❑ Yes ❑ No	❑ Yes ❑ No	Plan Name:

Subscriber's Signature _____ **Date**_____