



CITY OF BAKERSFIELD

Human Resources Division
1600 Truxtun Ave.
Bakersfield, CA. 93301
Questions? Call 661-326-3773
Fax: 661-852-2070
admhrs@bakersfieldcity.us

Retiree Benefit Cancellation Request

This form is designed to cancel retiree benefit coverage.
Please return completed and signed form to above address, attention Benefits.

(Please print)

Retiree Name:	Social Security #:	Date of Birth:	Phone Number: ()
Address/City/State:	Coverage Termination Effective Date:	Email Address:	

Spouse Name (if applicable):	Social Security #:	Date of Birth:	Phone Number: ()
Address/City/State:	Coverage Termination Effective Date:	Email Address:	

Declination/Termination of Coverage: I request to decline/terminate the following benefit plans (select benefit(s) below):

- Medical
- Dental

My reason is (select one below):

- Cost
- Other Group Coverage
- Other: _____

***I understand that I cannot be reinstated on the City of Bakersfield's health insurance once I have cancelled my coverage.

Signature: _____

Date: _____

IMPORTANT INFORMATION

- Effective date of coverage cancellation must be the 1st of the designated month (cannot be retroactive).
- If form is received after the 15th of the month, a billing statement will already have been processed and mailed to retiree for payment.
- If you have a change of address, please go online and print out, complete and return the Retiree Change of address form.

THIS SECTION FOR OFFICE USE ONLY (CHECK OFF SITES/BENEFITS CHANGED)		
Census <input type="checkbox"/>	United Concordia <input type="checkbox"/>	BS <input type="checkbox"/>
HTE <input type="checkbox"/>	MES <input type="checkbox"/>	KP <input type="checkbox"/>