Retiree Cancellation of Benefits

This form is to request the cancellation of retiree Health & Welfare Benefits with Southwestern Community College District.

Retiree Name (First, Middle, Last):

_____

Plan(s) Electing to Cancel:

- ☐ Medical
- ☐ Dental
- ☐ Vision

Effective Date of Cancellation:

_____

Coverage Cancellation Acknowledgment

By signing below, I acknowledge that I am voluntarily electing to cancel my enrollment in the above plan(s) offered by Southwestern Community College. I understand that by declining this coverage, I am waiving my right to enroll in this plan at any point in the future.

Signature: _____ Date: _____