

DATE: _____

TO: HUMAN RESOURCES DEPARTMENT

I, _____
PLEASE PRINT FULL NAME

MAILING ADDRESS CITY STATE ZIP TELEPHONE #

hereby wish to cancel the following plan(s):

- BCBS HMO BLUE Deductible plan - Individual
- BCBS HMO BLUE Deductible plan - Family

- BCBS PPO Deductible plan - Individual
- BCBS PPO Deductible plan - Family

- BCBS Medex Plan

- Delta Dental Basic Individual plan
- Delta Dental Basic Individual + One plan
- Delta Dental Basic Family plan

- Delta Dental Enhanced Individual plan
- Delta Dental Enhanced Individual + One plan
- Delta Dental Enhanced Family plan

- Boston Mutual Basic Life Insurance coverage
- Boston Mutual Voluntary Life Insurance coverage

The effective date of cancellation is _____.

EMPLOYEE/RETIREE SIGNATURE

HR Office Use Only	
<input type="checkbox"/> MTR	<input type="checkbox"/> BS
<input type="checkbox"/> HRB	<input type="checkbox"/> Deductions
<input type="checkbox"/> BCBS	<input type="checkbox"/> Groups
<input type="checkbox"/> BM	<input type="checkbox"/> Ins. Class
<input type="checkbox"/> DD	<input type="checkbox"/> Archive