



For office use only. Retirement number:

Medical or Dental Coverage Cancellation

Use this form to cancel your medical or dental coverage with the Seattle City Employees' Retirement System. Please help us to serve you by printing legibly.

Check all coverage that you wish to cancel:

Medical Coverage:

- Retiree
Spouse or domestic partner
Dependent(s)

Please provide the name(s) of spouse, domestic partner, or dependent(s) whose coverage you wish to cancel:

Dental Coverage:

- Retiree
Spouse or domestic partner
Dependent(s)

Please provide the name(s) of spouse, domestic partner, or dependent(s) whose coverage you wish to cancel:

I hereby request that the above coverage be cancelled effective on (date):

I understand that by canceling medical or dental coverage at this time, I will not have the option of re-enrolling myself, my spouse, domestic partner, or my dependents in the group plan.

Print your name:

Member signature: Date:

The last four digits of your Social Security number:

The telephone number or e-mail where we can contact you about this request: