



MEDICAL/DENTAL PLAN CANCELLATION FORM

Please print all information

Subscriber Last Name		First Name		Middle Initial
Social Security #	Gender <i>(check one)</i> <input type="checkbox"/> M <input type="checkbox"/> F	Retirement Date	<u>Cancellation Effective Month</u>	
Mailing Address				
c/o Trustee			P.O. Box	
Street			Apt./Suite #	
City		State	Zip Code	
Personal E-mail			8 am-5 pm Phone #	

PLEASE CANCEL MY LACERS RETIRED MEDICAL/DENTAL PLANS AS INDICATED BELOW

Please check the box next to the medical/dental plan you are cancelling

MEDICAL PLANS

- Anthem Blue Cross PPO/Medicare Supplement
- Anthem Blue Cross HMO – CA
- Kaiser Permanente/Senior Advantage – CA
- SCAN: *(check one)* CA AZ
- SecureHorizons – CA
- SecureHorizons: *(check one)* AZ NV

DUAL CARE HMO MEDICAL PLANS

- SCAN/Anthem Blue Cross HMO – CA
- SecureHorizons/Anthem Blue Cross HMO – CA

DENTAL PLANS

- MetLife
- SafeGuard

Consolidated Omnibus Budget Reconciliation Act (COBRA)

- My covered dependent(s) and I are covered by another medical and/or dental plan; therefore, I do **NOT** want COBRA continuation.

Signature: _____ Date: _____

FOR OFFICE USE ONLY			
Initials:	MOU:	Effective Date:	Retirement Roll Date: