LACERS
LOS ANGELES CITY EMPLOYEES' RETIREMENT SYSTEM
Securing Your Tomorrows

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2020 Medical/Dental Plan Cancellation Form

1. SUBSCRIBER INFORMATION			
Last Name	**First Name**	**Middle Name**	
Social Security Number	**Medicare Beneficiary Identifier**		**Gender**
Street Address	**City**	**State**	**Zip Code**
Email Address	**Daytime Phone Number**	**Cancellation Effective Month**	

2. CANCEL MY LACERS RETIRED MEDICAL/DENTAL PLANS AS INDICATED BELOW:
Medical Plans
☐ Anthem Blue Cross PPO/Life & Health (Medicare Supplement)
☐ Anthem Blue Cross HMO - CA
☐ Kaiser Permanente/Senior Advantage – CA 225576-0
SCAN Health Plan: ☐ CA
☐ UnitedHealthcare Medicare Advantage HMO - CA
UnitedHealthcare Medicare Advantage HMO: ☐ AZ ☐ NV (check one)
Dual Care HMO Medical Plans
☐ SCAN Health Plan/Anthem Blue Cross HMO - CA
☐ UnitedHealthcare Medicare Advantage HMO/Anthem Blue Cross HMO - CA
Dental Plans
☐ Delta Dental PPO℠ - 17228
☐ DeltaCare® USA HMO - 76992 for ____ CA 00001 or____ parts of NV only 00003

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:

ADA NOTICE

As a covered entity under Title II of the Americans with Disabilities Act, the City of Los Angeles does not discriminate on the basis of disability and, upon request, will provide reasonable accommodations to ensure equal access to its programs, services and activities.