

2022 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/Medicare Preferred PPO (Medicare Advantage with Rx)
 Anthem Blue Cross HMO - CA
 Kaiser Permanente/Senior Advantage (SoCal) 225576-0 (NoCal) 605559-0 (check one)
 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 PPOSM - 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.