LACERS
LA CITY EMPLOYEES' RETIREMENT SYSTEM

Mailing Address: PO Box 512218, Los Angeles, CA 90051-0218
www.lacers.org | lacers.services@lacers.org | Mail Stop 175
(800) 779-8328 | RTT (888) 349-3996 | Fax (213) 473-7297

2025 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**	**Cancellation Effective Month**	

2. CANCEL MY LACERS RETIRED MEDICAL/DENTAL PLANS AS INDICATED BELOW:
Medical Plans: ***Additional form(s) required if you and/or your dependent(s) has Medicare***
☐ Anthem Blue Cross PPO/Medicare Preferred PPO (Medicare Advantage with Rx)
☐ Anthem Blue Cross PPO/Medicare Supplement (Medicare Supplement with Rx)
☐ Anthem Blue Cross HMO – CA
Kaiser Permanente/Senior Advantage (check one): ☐ (SoCal) 225576-0 ☐ (NoCal) 605559-0
SCAN Health Plan: ☐ CA
UnitedHealthcare Medicare Advantage HMO (check one): ☐ AZ ☐ CA ☐ NV
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.

I understand that this form is required to be submitted by the 10th of the month to be effective the 1st of the following month. I understand that I cannot re-enroll in a LACERS plan until the next annual Open Enrollment period with coverage effective the following January 1.

Member's Signature **Date**

See Page 2 for how to submit this form to LACERS

FOR OFFICE USE ONLY			
INITIALS	MOU	EFFECTIVE DATE	RETIREMENT ROLL DATE

SUBMIT COMPLETED FORMS TO LACERS

SECURE DOCUMENT UPLOAD:	**lacers.org/secure-document-upload**
EMAIL:	**LACERS.health@lacers.org**
MAIL:	**LACERS, Attn: Health Benefits Administration** **PO Box 512218, Los Angeles, CA 90051-0218**
DROP OFF/VISIT:	**977 N. Broadway, Los Angeles, CA 90012-1728**
FAX:	**(213) 473-7284**