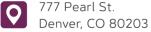


Health Insurance Disenrollment Form

To disenroll from medical, dental, and/or vision insurance offered through DERP, this form must be completed, signed, and submitted to DERP. Disenrollment is the last day of the month following receipt of this form.

If you want to re-enroll in medical, dental, and/or vision insurance through DERP you will have to wait until the annual Open Enrollment period unless you experience a qualifying life event. If you have a qualifying life event you can re-enroll. To re-enroll you must submit the DERP Health Insurance Election Form within 30 days of your qualifying life event.

Step 1 - Provide Your	Information (All fields must	be populated.)			
Name (First, Middle Initial, L	ast)		DERP ID (call our office if you don't know your ID)			
Address and/or P.O. Box, (City, State, Zip Code	2				
Personal Email Address		Personal Phone Number				
Step 2 - Tell Us Why	Are You Disenro	olling and the	e Effective Da	ite		
Voluntary	Medicare Eligible		er vide explanation)			
Effective Date Disenrollment is the last day	of the month follow	ing receipt of th	is form.			
Step 3 - Tell Us the In	surance Plan(s)) You Want t	o Disenroll Fr	om		
Medical						
Check the box next to the medical plan.	medical plan you a	re disenrolling	from. Do not che	eck a box if you	do not want to o	disenroll from a
Kaiser Permanente HDHP	nte Kaiser Permanente DHMO		UnitedHealthcare HDHP		UnitedHealthcare CDP	
Dental						
Check the box next to the dental plan.	dental plan you are	e disenrolling fr	om. Do not chec	k a box if you d	o not want to di	senroll from a
Cigna DHMO	Cigna PPO Low	Cigna PPO High	Delta EPO		Delta PPO Low	Delta PPO High
Vision						
Check the box next to VSP	if you want to dise	nroll. Do not cl	neck the box if yo	ou do not want	to disenroll from	n VSP.
VSP						







Step 4 - Tell Us Who You Are Disenrolling

Name (First, Middle Initial, Last)	Relation	Ger	nder	Birth Date	SSN		ncel Cand			Cancel Vision	
	Self	М	F			Υ	N	Υ	N	Υ	N
	Spouse	М	F			Υ	N	Υ	N	Υ	N
	Child	М	F			Υ	N	Υ	N	Υ	N
	Child	М	F			Υ	N	Υ	N	Υ	N
	Child	М	F			Υ	N	Υ	N	Υ	N
	Child	М	F			Υ	N	Υ	N	Υ	N
	Child	М	F			Υ	N	Υ	N	Υ	N
	Child	М	F			Υ	N	Υ	N	Υ	N
	Child	М	F			Υ	N	Υ	N	Υ	N
	Child	М	F			Υ	N	Υ	N	Υ	N

Step 5 - Certification Your Health Insurance Disenrollment Form will not be processed if it is not signed.

By signing this form, I am agreeing with the following statements:

- ✓ I understand I am requesting cancellation of the medical, dental, and/or vision health insurance coverages noted on this form for myself and/or my dependents.
- ✓ I understand I can only re-enroll in medical, dental, and/or vision health insurance offered through DERP during the annual Open Enrollment period or if I have a qualifying life experience.
- ✓ I understand if I experience a qualifying life event I must submit a DERP <u>Health Insurance Election Form</u> within 30 days of my qualifying life event to re-enroll in the medical, dental, and/or vision health insurance offered through DERP.

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Member Signature			Date		

Step 6 - Submit Your Health Insurance Election Form

Email your completed and signed form to Help@DERP.org, mail to the address below, or drop off at our office.

