DERP Denver Employees Retirement Plan

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INSURANCE DISENROLLMENT
PRE-MEDICARE MEDICAL, DENTAL, AND VISION

Effective Date: _____ ***Note: Disenrollment from any insurance is always the last day of any calendar month.***

Print name: _____ **DERP ID #:** _____
(Last Name, First Name, M.I.)

Last Four Digits of SSN: _____ **Birth date:** _____ **Gender:** M / F

Residence Address: _____
(Street, Avenue, Road, etc.) *(City, State, Zip Code)* *(County)*

Daytime Telephone Number: _____ **Email Address:** _____

HEALTH PLAN: ***Note: Leave blank if you are not disenrolling from your health plan.***

Which plan do you wish to disenroll from? **(Check one)**

☐ Denver Health Medical Plan HDHP ☐ Denver Health Medical Plan HMO ☐ Kaiser Permanente HDHP
☐ Kaiser Permanente DHMO ☐ United Healthcare HDHP ☐ United Healthcare CDP

DENTAL PLAN: ***Note: Leave blank if you are not disenrolling from your dental plan.***

Which plan do you wish to disenroll from? **(Check one)**

☐ CIGNA DHMO ☐ CIGNA PPO Low ☐ CIGNA PPO High ☐ Delta EPO ☐ Delta PPO Low ☐ Delta PPO High

VISION PLAN: ***Note: Leave blank if you are not disenrolling from your vision plan.***

Which plan do you wish to disenroll from? **(Check one)**

☐ VSP

REASON FOR DISENROLLMENT:

☐ Voluntary Disenrollment

☐ Medicare Eligible

☐ Dependent(s) No Longer Eligible

☐ Involuntary Disenrollment: Non-payment of Premiums

☐ Other *(please provide explanation)*: _____

FAMILY MEMBER DISENROLLMENT INFORMATION

Last Name, First, MI	Relation	Gender	Date of Birth	SSN	Cancel Health?	Cancel Dental?	Cancel Vision?
	Self	M / F			Y / N	Y / N	Y / N
	Spouse	M / F			Y / N	Y / N	Y / N
	Child*	M / F			Y / N	Y / N	Y / N
	Child*	M / F			Y / N	Y / N	Y / N
	Child*	M / F			Y / N	Y / N	Y / N
	Child*	M / F			Y / N	Y / N	Y / N
	Child*	M / F			Y / N	Y / N	Y / N
	Child*	M / F			Y / N	Y / N	Y / N
	Child*	M / F			Y / N	Y / N	Y / N
	Child*	M / F			Y / N	Y / N	Y / N

Signature:_____ **Date:**_____

Signature Certification

By signing this form, I am agreeing with the following: I understand that I am requesting cancellation of the above insurance coverages and that I am only allowed to re-enroll during the Plan's annual Open Enrollment (OE) period or if I have a qualifying life status change (LSC). I also understand that if I have a qualifying LSC, I have 30 calendar days to notify the Plan and, if necessary, re-enroll in one of the insurance options available to me.