Human Resources
EMPLOYEE
BENEFITS AND SERVICES

RETIREE
MEDICAL AND/OR DENTAL PLAN
CANCELLATION FORM

San Bernardino County
Employee Benefits and Services Division (EBSD)
157 West Fifth Street, First Floor
San Bernardino, CA 92415-0440
(909) 387-5787 Fax (909) 387-5566

FOR OFFICE USE ONLY			
Effective Date	Month	Day	Year
Group #.			
Employee ID #			

A I CHOOSE TO CANCEL MY MEDICAL AND/OR DENTAL COVERAGE

❑ Medical plan name _____

❑ Dental plan name _____

B RETIREE INFORMATION

1. Social Security No.	2. Check One: ❑ Male ❑ Female	3. Date Of Birth Month Day Year	4. Check One: ❑ Married ❑ Widowed ❑ Single ❑ Divorced ❑ Domestic Partner
5. Last Name	6. First Name	7. MI	8. For Name Change, List Former Name Here
9. Mailing Address Check Here If New Address ❑			10. Home Phone ( ) Alternate Phone ( )
11. City	12. State	13. Zip Code	

Subscriber's Signature _____ Date_____

RETURN FORM TO:

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