Human Resources Division
1600 Truxtun Ave.
Bakersfield, CA. 93301
Questions? Call 661-326-3773
Fax: 661-852-2070
admhrs@bakersfieldcity.us

CITY OF BAKERSFIELD

Retiree Benefit Cancellation Request

This form is designed to cancel retiree benefit coverage.
Please return completed and signed form to above address, attention Benefits.

(Please print)

Retiree/Subscriber Name:	Social Security #:	Date of Birth:	Phone Number: ( )
Address/City/State:	Email Address:		Coverage Termination Effective Date (Last day of Month):

Declination/Termination of Coverage: I request to decline/terminate the following benefit plans (select benefit(s) below):

MEDICAL

- ☐ **Blue Shield PPO**
- ☐ **Blue Shield Advantage Plan 65+**
- ☐ **Kaiser Senior Advantage Plan**
- ☐ **Kaiser HMO/MES Vision**
- ☐ **Kaiser HMO Deductible/MES Vision**

DENTAL

- ☐ **United Concordia Dental DHMO**

My reason is (select one below):

- ☐ Cost
- ☐ Other Group Coverage
- ☐ Other: _____

*****I understand that I cannot be reinstated on the City of Bakersfield's health insurance once I have cancelled my coverage.**

Signature: _____ **Date:** _____

IMPORTANT INFORMATION

- Effective date of coverage cancellation must be the 1st of the designated month (cannot be retroactive).
- If form is received after the 15th of the month, a billing statement will already have been processed and mailed to retiree for payment.
- If you have a change of address, please complete and return the Retiree Change of address form.

THIS SECTION FOR OFFICE USE ONLY (CHECK OFF SITES/BENEFITS CHANGED)		
Census ☐	United Concordia ☐	BS ☐
Billing ☐	MES ☐	KP ☐