REQUEST TO DELETE DEPENDENTS
BCBS MEDICAL, DENTAL, AND VISION POLICY

Name: _____ **Munis ID:** _____

Status (please check one)**:** ☐ **Active** ☐ **Retiree**

I am requesting that the following dependent(s) be removed from my Blue Cross Blue Shield Policy-

☐ **Medical** ☐ **Dental** ☐ **Vision** Effective date: _____

Request to change policy will be implemented at the beginning of the next month.

Please provide the following information on the dependent that you would like to have terminated from the policy: (Address is required in order to forward COBRA insurance information)

1. Name: _____ SS#_____
   Address: _____
   Date of Birth_____ Relationship to you_____
   Reason for termination_____

2. Name: _____ SS#_____
   Address: _____
   Date of Birth_____ Relationship to you_____
   Reason for termination_____

By deleting the above dependent(s) from my coverage, my plan now becomes:

MEDICAL	**DENTAL**	**VISION**
☐ **Single**	☐ **Single**	☐ **Single**
☐ **Two Party**	☐ **Two Party**	☐ **Two Party**
☐ **No Change, still Family**	☐ **No Change, still Family**	☐ **No Change, still Family**

Employee's Signature: _____ **Date:** _____

Please note that open enrollment is during August and September of every year. You will not be able to add family members back to your plan outside of open enrollment unless you have experienced a change in family status or loss/change of other insurance.

RETIREES – Please be aware that if you elect to remove and then add a family member back to your plan at ANY later date, the Board of Education will NOT contribute to their premium. It will be at FULL COST TO YOU, the retiree.

Please return completed form to the Benefits Office

Date Received in Benefits Office_____ Date changed in MUNIS_____
Date notification sent to BCBS_____ Date Cobra filed_____