CONTRA COSTA COMMUNITY COLLEGE DISTRICT

FORM FOR DELETING GROUP HEALTH COVERAGE

SECTION 1: EMPLOYEE/RETIREE INFORMATION		
Employee/Retiree First Name	**Employee/Retiree Last Name**	
Address	**City**	**Zip Code**
Home or Cell Phone Number	**Social Security Number**	**Birth Date**

SECTION 2: STATUS	
	Full-time Faculty
	Part-time Faculty
	Local 1
	Manager
	Supervisor
	Confidential
	Retiree
	Surviving Spouse

SECTION 3: LOCATION	
	CCC
	DVC
	SRC
	LMC
	Brentwood
	District Office

SECTION 4: DELETE COVERAGE FOR	
	Self
	Spouse/Domestic Partner
	Dependents
SECTION 5: UNDER PLAN(S)	
	Medical
	Dental
	Vision
	Employee Assistance
	Life Insurance
	Other

Deleting Group Health Coverage Statement

I understand that by signing this form I am deleting health coverage for myself and/or eligible dependents and I will not be able to enroll in health coverage until the next open enrollment period. However, if a qualifying or life event occurs I will have 30 days immediately following the qualifying or life event to submit completed enrollment forms, birth certificates for dependents, marriage license for spouse, affidavit of domestic partnership for domestic partners and evidence of the lost coverage to enroll in health coverage.

Divorce Decree or Evidence of Other Coverage

I also understand in order to delete health coverage for myself, a spouse and/or dependent(s) a divorce decree or evidence of other coverage must be submitted along with this form.

SECTION 6: REASON FOR DELETING COVERAGE	

SECTION 7: INDICATE BELOW WHOSE COVERAGE WILL BE DELETED					
Termination Date	**First Name**	**Last Name**	**SSN**	**Birth Date**	**Relationship**

SECTION 8: SIGNATURE - I certify that the information provided above is accurate and correct.			
Signature		**Date**	