Notice to Discontinue Health Care Coverage

Employee Name: _____ EIN: _____

Social Security Number: _____

Please read carefully and sign below

I wish to discontinue my health care coverage. I realize that by discontinuing my coverage with the City's group health care plan ***I will not be eligible to rejoin the City's group health care at any future date, unless I provide proof of continuous outside health care coverage from time of cancellation of City coverage through time of re-application***. I also understand that I will receive a package from the City's Human Resources Office offering COBRA and that I may choose to participate in the plan.

_____ _____

Retiree Date

_____ _____

Witness Date