PERMANENTE MEDICINE®
Southern California
Permanente Medical Group

Retiree Health Insurance (Multi-Site) Request to Cancel Coverage Form

Name:_____(Please print)

Address: _____

City, State, Zip; _____

Last 4 digits of your Social Security Number: _____

_____

I understand that my decision to cancel Health Insurance (Multi-Site) coverage is revocable in the future as long as I have been continuously covered under another health plan. Please initial the following acknowledging cancellation of coverage's:

_____ I elect to cancel Health Insurance

In order to elect coverage at a future date, it will be necessary for you to provide documentation of continuous coverage from the date coverage was cancelled with SCPMG. If you are not continuously covered under another health plan, you will not be able to elect coverage at a future time. If you are attempting to enroll into another policy, do not discontinue coverage until your replacement coverage is active.

Coverage will be discontinued on the first day of the month following receipt of your properly completed Request to Cancel Coverage Form and any other necessary forms. If you have questions on the completion of this form, please call 1-877-608-0044.

_____ _____

Signature Date

KAISER PERMANENTE®