



Denver Employees Retirement Plan
 777 Pearl Street
 Denver, Colorado 80203
 Ph. - 303/839-5419
 Fax - 303/839-9525
www.derp.org
mbrsvs@derp.org

INSURANCE DISENROLLMENT FORM
Pre-Medicare Medical, Dental, and Vision

Effective Date: _____ *Note: Disenrollment from any insurance is always the last day of any calendar month.*

Print name: _____ **DERP ID #:** _____
 (Last Name, First Name, M.I.)

Last Four Digits of SSN: _____ **Birth date:** _____ **Gender:** M / F

Residence Address: _____
 (Street, Avenue, Road, etc.) (City, State, Zip Code) (County)

Daytime Telephone Number: _____ **Email Address:** _____

HEALTH PLAN: *Note: Leave blank if you are not disenrolling from your health plan.*

Which plan do you wish to disenroll from? **(Check one)**

- Denver Health Medical Plan HDHP
 Denver Health Medical Plan HMO
 Kaiser Permanente HDHP
 Kaiser Permanente DHMO
 United Healthcare HDHP
 United Healthcare CDP

DENTAL PLAN: *Note: Leave blank if you are not disenrolling from your dental plan.*

Which plan do you wish to disenroll from? **(Check one)**

- CIGNA DHMO
 CIGNA PPO Low
 CIGNA PPO High
 Delta EPO
 Delta PPO Low
 Delta PPO High

VISION PLAN: *Note: Leave blank if you are not disenrolling from your vision plan.*

Which plan do you wish to disenroll from? **(Check one)**

- VSP

REASON FOR DISENROLLMENT:

- Voluntary Disenrollment
 Medicare Eligible
 Dependent(s) No Longer Eligible
 Involuntary Disenrollment: Non-payment of Premiums
 Other (please provide explanation): _____

FAMILY MEMBER DISENROLLMENT INFORMATION

<u>Last Name, First, MI</u>	<u>Relation</u>	<u>Gender</u>	<u>Date of Birth</u>	<u>SSN</u>	<u>Cancel Health?</u>	<u>Cancel Dental?</u>	<u>Cancel Vision?</u>
	Self	M / F			Y / N	Y / N	Y / N
	Spouse	M / F			Y / N	Y / N	Y / N
	Child*	M / F			Y / N	Y / N	Y / N
	Child*	M / F			Y / N	Y / N	Y / N
	Child*	M / F			Y / N	Y / N	Y / N
	Child*	M / F			Y / N	Y / N	Y / N
	Child*	M / F			Y / N	Y / N	Y / N
	Child*	M / F			Y / N	Y / N	Y / N
	Child*	M / F			Y / N	Y / N	Y / N
	Child*	M / F			Y / N	Y / N	Y / N

Signature: _____ **Date:** _____

Signature Certification

By signing this form, I am agreeing with the following: I understand that I am requesting cancellation of the above insurance coverages and that I am only allowed to re-enroll during the Plan's annual Open Enrollment (OE) period or if I have a qualifying life status change (LSC). I also understand that if I have a qualifying LSC, I have 30 calendar days to notify the Plan and, if necessary, re-enroll in one of the insurance options available to me.