



State of Rhode Island & Providence Plantations  
**DEPARTMENT OF ADMINISTRATION**  
 Office of Employee Benefits  
 One Capitol Hill  
 Providence, RI 02908-5864  
 Phone: (401) 222-3160 Fax: (401)222-6391

## RETIREE HEALTH CARE CANCELLATION FORM

INSTRUCTIONS: PLEASE PRINT OR TYPE IN BLACK INK

### RETIREE INFORMATION (Must be completed in all cases)

RETIREE NAME:	FIRST	MIDDLE	LAST
SOCIAL SECURITY NUMBER	TELEPHONE NUMBER (INCLUDE AREA CODE) ( )		
STREET ADDRESS OR PO BOX	CITY	STATE	ZIP CODE

### CANCELLATION OF HEALTH CARE

REASON FOR CANCELLATION: \_\_\_\_\_

CANCEL MY HEALTH CARE COVERAGE. EFFECTIVE DATE: \_\_\_\_\_

CANCEL MY SPOUSE'S HEALTH CARE COVERAGE. EFFECTIVE DATE: \_\_\_\_\_

SPOUSE'S NAME: \_\_\_\_\_ SPOUSE'S SSN: \_\_\_\_\_

IF YOU ARE CANCELLING A SPOUSE'S COVERAGE BECAUSE OF HIS/HER DEATH, PLEASE ATTACH A COPY OF THE DEATH CERTIFICATE SO IT CAN BE FORWARDED TO THE MEDICAL INSURANCE PROVIDER.

**NOTE:** FORM MUST BE RECEIVED BY THE 15<sup>TH</sup> OF THE MONTH PRIOR TO THE EFFECTIVE DATE ABOVE.  
 IF RECEIVED AFTER THE 15<sup>TH</sup> OF THE MONTH, THEN THE EFFECTIVE DATE WILL BE THE 1<sup>ST</sup> OF THE MONTH FOLLOWING.

*I.E. FORM RECEIVED ON FEBRUARY 14<sup>TH</sup>, THE EFFECTIVE DATE WOULD BE MARCH 1<sup>ST</sup>.  
 FORM RECEIVED ON FEBRUARY 16<sup>TH</sup>, THE EFFECTIVE DATE WOULD BE APRIL 1<sup>ST</sup>.*

### SIGNATURE

RETIREE SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

SPOUSE OF STATE  
 RETIREE SIGNATURE,  
 IF APPLICABLE: \_\_\_\_\_ DATE: \_\_\_\_\_

### OFFICE OF EMPLOYEE BENEFITS

OFFICE USE ONLY

Accepted by: \_\_\_\_\_ Date Received: \_\_\_\_\_