

# Retiree Medical, Dental and/or Vision Cancellation Form

Complete this form only if you wish to cancel your current medical, dental and/or vision coverage through the City of Tucson group plan.

Please cancel my City of Tucson group coverage for the policies marked below for myself and my dependents.

- I understand that I and my qualifying dependent(s) (if applicable) will not be permitted to (re)join a City of Tucson plan except during Open Enrollment or due to a qualifying life event, provided we still qualify under the terms of the City's programs and meet prescribed deadlines
- Additionally, I understand that I and my qualifying dependent(s) (if applicable) **will not be permitted to (re)join a City of Tucson dental or vision** plan unless I provide acceptable proof of other continuous dental/vision insurance coverage by prescribed deadlines
- For details, visit the Insurance Handbook at [www.tucsonaz.gov/insurance](http://www.tucsonaz.gov/insurance)

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Terminate my current **medical** enrollment effective the last day of the month of \_\_\_\_\_, 20\_\_\_\_. (Effective dates must be *prospective*. They may not be *retroactive*. For example, if the COT Benefits Office receives your form in July, you may drop coverage effective the following August 1<sup>st</sup> or later.)

Terminate my current **dental** enrollment effective the last day of the month of \_\_\_\_\_, 20\_\_\_\_. (Effective dates must be *prospective*. They may not be *retroactive*. For example, if the COT Benefits Office receives your form in July, you may drop coverage effective the following August 1<sup>st</sup> or later.)

Terminate my current **vision** enrollment effective the last coverage date through which Avesis received my correct, timely premium payment. (The COT Benefits Office staff will confirm your last paid-through date with Avesis to determine the coverage end date.)

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Retiree's Name (printed legibly): \_\_\_\_\_

Retiree's signature: \_\_\_\_\_

Retiree's address: Street \_\_\_\_\_

City, State, ZIP \_\_\_\_\_

Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Date: \_\_\_\_\_ SSN or Employee ID: \_\_\_\_\_

Your Social Security information is considered confidential and will not be sold, shared or provided to any person or organization for marketing, sales, or for any other purpose not related to discontinuing insurance coverage. It is for the sole use of the City of Tucson.

**Return your form to:**

City of Tucson Benefits Office  
PO Box 27210, Tucson, AZ 85726-7210  
Phone: 520-791-4597 FAX: 520-791-5942