



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)222-2964

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 15TH OF THE MONTH PRIOR TO THE EFFECTIVE DATE ABOVE.
 IF RECEIVED AFTER THE 15TH OF THE MONTH, THEN THE EFFECTIVE DATE WILL BE THE 1ST OF THE MONTH FOLLOWING.*

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

SIGNATURE

RETIREE SIGNATURE: _____ DATE: _____

SPOUSE OF STATE
 RETIREE SIGNATURE,
 IF APPLICABLE: _____ DATE: _____

OFFICE OF EMPLOYEE BENEFITS

OFFICE USE ONLY

Accepted by: _____ Date Received: _____