Los Rios Community College District

MEDICAL & DENTAL INSURANCE CANCELATION REQUEST ~ ADJUNCT FACULTY ~

Please cancel enrollment for me and my family (if applicable) in the following plan(s):

- ☐ Kaiser (HMO/DHMO), SHP HMO, or WHA (HMO/1800 HSA HMO)
- ☐ Delta Dental

This request is being made due to:

- ☐ Open Enrollment
- ☐ Mid-Year Qualifying Event

Complete the boxed section below if cancelation is requested outside of Open Enrollment.

If cancelation is requested outside of the Open Enrollment period, I understand that I must have a qualifying change-in-status or HIPAA special enrollment event and that original cancelation forms must be received in the Employee Benefits Department within 31 days of the event date (or 60 days for certain HIPAA qualifying events).

Reason for Cancelation w/ Qualifying Event Date:

Example: Got married; enrolling in spouse's medical insurance. (Marriage) Date: 9/22/15.

Event: _____

Date: _____

I understand that medical and/or dental coverage which is canceled at my request will be terminated effective the first day of the new semester's coverage period or the first of the month following the qualifying change-in-status or HIPAA special enrollment event date.

I will be ineligible to re-enroll until March 1st or September 1st following 18 months from the last day of the month in which coverage is terminating. However, if I have been continuously covered by other group health or dental insurance and subsequently experience a new mid-year Change-in-Status or HIPAA Qualifying Event including losing that other group coverage, I can re-enroll within 31 days of loss of coverage (provided all other eligibility requirements are met.)

Name: _____ **Employee ID:** _____

Signature: _____ **Date:** _____

Questions about this form and re-enrollment restrictions may be directed to the Los Rios Employee Benefits Department at (916) 568-3070 or Benefits@losrios.edu.

EMPLOYEE BENEFITS USE ONLY:

Effective Date of Cancelation: _____