

**LOS RIOS COMMUNITY COLLEGE DISTRICT**

1919 Spanos Court, Sacramento, CA 95825 \* 916.568.3070

Email: [Benefits@losrios.edu](mailto:Benefits@losrios.edu) \* Website: <http://www.losrios.edu/business/benefits.php>

**Dental Insurance Cancellation Request**

This is to acknowledge my request to cancel my District dental plan through Delta Dental.

\_\_\_\_\_ **I am requesting cancellation of my District dental plan during Open Enrollment.**

\_\_\_\_\_ **I am requesting cancellation of my District dental plan OUTSIDE of Open Enrollment.**

*(Must check one box)*

**Important Eligibility and Coverage Information**

**---Qualifying Family Status Changes ---**

Normally you cannot cancel your dental plan in which you participate, except during a dental open enrollment.

An exception to waiting for open enrollment would be by reason of a Qualifying Family Status Change event. You have only **31 calendar days** from the date of your qualifying event to notify the Employee Benefits Department and submit the required forms. Acceptable Family Status Changes for cancelling coverage are listed below.

***Please check the applicable Qualifying Event if you are cancelling outside of Open Enrollment:***

- Entering into Marriage/Domestic Partnership and adding onto spouse/domestic partner's plan
- Commencement of your spouse/domestic partner's employment (which triggered employer-sponsored dental coverage under your spouse/domestic partner)
- A significant change in dental coverage provided by your spouse/domestic partner's employer that affects you or your spouse/domestic partner, including open enrollment under his/her plan.

If you have a qualifying Family Status Change, you may revise your benefits only in ways that are consistent with that change. For instance, if you marry or enter a domestic partnership, you could drop our dental insurance if you are adding onto your spouse/domestic partner's dental plan. **Again, to make plan changes, this original form must be received by Employee Benefits within 31 calendar days of the qualifying event with documentation of the new coverage.**

\_\_\_\_\_ *Date of Qualifying Event*

**I understand that I will not be able to enroll in the District dental plan until that later of the passage of 24 months or the next dental Open Enrollment (*unless I experience a loss of coverage Qualifying Event*) and the benefit level will restart at 70% due to the break in coverage.**

\_\_\_\_\_ *Effective Date of Cancellation*

Name: \_\_\_\_\_ Employee ID# \_\_\_\_\_

Signature \_\_\_\_\_ Date: \_\_\_\_\_