Benefits Cancellation Form

Faculty & Staff

Important Information

- **When to Use This Form** – Use this form to cancel your benefits and/or your dependent's benefits within 30 days of a qualifying event.
- **Complete the Form in its entirety** – This form will be returned to you if it is not filled in completely.
- **DEADLINE – Submit this form within 30 days of your qualifying event. Do not forget to sign this form because it cannot be processed without a signature.**

Employee Information

First Name:_____ Middle Initial:_____ Last Name:_____

DU ID Number (Required):_____

Home Telephone:_____ Campus Telephone:_____

Email Address:_____

Cancellation Reason

- **IRS Qualifying Event** **Date of Event**_____ **Effective Date of Cancellation**_____
  (mm/dd/yyyy) (mm/dd/yyyy)

You have 30 days from the date of the qualifying event to complete and return this form. Last day of coverage must be the last day of the month.

Type of Event:

- Marriage– I will be insured through my partner's employer benefits
- Divorce– Spouse/Partner is eligible for COBRA; please provide an address for your spouse/partner:_____
- My spouse/partner and/or child is eligible for insurance through his/her employer benefits.
- I have insurance through my new/second employer.
- I will be covered under my spouse/partner's employer plan
- My child is ineligible for benefits because he/she is age 26; child is eligible for COBRA. Provide an address for your child: to

  _____ _____
  (mm/dd/yyyy) (mm/dd/yyyy)

- Other:_____

Section 1: Cancel Insurance Coverage

Effective Date of Cancellation: _____ (must be the last day of the month)
(mm/dd/yyyy)

Check	Coverage		Name: First, M.I., Last
• Remove	• Medical • Dental • Vision FSA	• Voluntary Life • Voluntary AD&D • Critical Illness Accidental	Employee (Myself)
• Remove	• Medical • Dental • Vision	• Voluntary Life • VoluntaryAD&D Critical Illness Accidental	Spouse / Partner
• Remove	• Medical • Dental • Vision	• Voluntary Life • Voluntary AD&D Critical Illness Accidental	Child
• Remove	• Medical • Dental • Vision	• Voluntary Life • Voluntary AD&D Critical Illness Accidental	Child
• Remove	• Medical • Dental • Vision	• Voluntary Life • VoluntaryAD&D Critical Illness Accidental	Child
• Remove	• Medical • Dental • Vision	• Voluntary Life • Voluntary AD&D Critical Illness Accidental	Child

Section 2: Authorization and Signature – Sign and Date

_____

Signature (If using electronic signature, please return this form) Date

How to Submit Your Cancellation Form

The preferred method is to complete this form electronically, and email it to:

Benefits@du.edu

By fax:

Attention:
Benefits, + X P D Q 5 H V R X U F H V
303-871-

Keep a copy of the fax transmission report with your form for your records.

In Person

Keep a copy for yourself and bring
yow1c enginal 63 3 Tw (e22j 0.04 Tw 31.559 0 T(o: 9.96 Tf 0.05 Tw [<0d (ep)Tj 022 05

0.04 T55C < BT