OBERLIN COLLEGE & CONSERVATORY | Department of Human Resources

Retiree Cancellation Form

Name: _____ **T#**_____

List the name(s) of the qualified dependent(s) whose coverage you are removing from your vision and dental plan below.

Check each plan you want changed. First and Last Name(s)	Dental	Vision					
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					

NOTE: RETIREE'S/SURVIVING SPOUSE OF RETIREE: If you are enrolled in the MedMutual Medicare Advantage Plan with prescription coverage, and you are declining coverage, please complete the Retiree Enrollment/Opt Out Form. This form is intended for Vision and Dental only.

First and Last Name:_____**Phone Number:** _____

Signature:_____ **Date:** _____

Effective Date:_____

Email form to: benefits@oberlin.edu **Phone (440) 775-8430** **Fax: (440) 775-8683**

US Mail: 173 W. Lorain Street Suite 205 Oberlin, OH 44074 **Campus Mail: Service Building Human Resources**