Benefits Cancellation Form

Name: _____ **T#** _____

Below list the name(s) of family member(s) whose coverage you are removing from your plan. **First and Last Name(s)**	*Optional Life	*Optional AD&D	*Long Term Care	Vision	Dental	*Medical	Office Use Only
SELF							

***RETIREE'S/SURVIVING SPOUSE OF RETIREE:** If you are enrolled in the MedMutual Medicare Advantage Plan with SilverScript - you must contact HR, Medical Mutual, and SilverScript to cancel coverage. Please complete the Retiree Enrollment Form by indicating you wish to "decline coverage", sign and send to Human Resources. *The original document is not required.*

Print Name: _____ **Date:** _____

Signature _____

Effective Date _____

Email Form to Human Resources: human.resources@oberlin.edu

Fax: (440) 775-8683

US Mail: 173 West Lorain Street Suite 205 Oberlin, OH 44074 Campus Mail: HR - Service Building Room 205

For Office Use Only: PDADEDN_____ PDABCOV_____ Web Entry Date:_____