OBERLIN COLLEGE & CONSERVATORY | Department of Human Resources

Benefits Cancellation Form

Name: _____ **T#** _____

Please list the name(s) of the qualified dependent(s) whose coverage you are removing from your plan below. Check make sure to check off each plan you want changed.

First and Last Name (s)	Medical	Dental	Vision	*Optional Life	*Optional AD&D

First and Last Name _____ Phone Number _____

Signature _____ Date _____

Effective Date _____

Upload form with supporting documentation to an HR submission folder. Click on the number for link:

(1) Qualifying Event (2) New Hire (3) Open Enrollment