



# Coverage Change/Cancellation Form

Employee last name, first name, middle initial: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Gender:  male  female

Date of birth (month/date/year): \_\_\_\_\_

Effective Date of Cancellation: \_\_\_\_\_

Type of coverage change:  Terminating Coverage  
 Cancel Dependent Listed Below Only

Type of plan change:  No Change  
 Change to individual plan  
 Change to family plan

**\* Dependent Relationship:** S=spouse, C=child, H=handicapped child, T=student

dependent last name	dependent first name	gender	* Dependent Relationship	date of birth mm/dd/yyyy
			<input type="checkbox"/> S <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T	/ /
			<input type="checkbox"/> S <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T	/ /
			<input type="checkbox"/> S <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T	/ /
			<input type="checkbox"/> S <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T	/ /

Employee Signature: \_\_\_\_\_

Please return this form to your benefits administrator. Do not return to VSP.