The City of
OKLAHOMA CITY
Employee Benefits Division
420 W. Main St., Ste. #110
Oklahoma City, OK 73102

First Name Last Name Peoplesoft ID

You have requested termination of one or more of your insurance coverage(s) as a retiree with the City of Oklahoma City. Please be aware that once you cancel coverage under a City sponsored insurance plan(s) you will not be allowed to re-enroll in the terminated City's insurance plan at a later date. In addition, if you terminate your coverage, your dependents and/or a spouse's coverage under the plan(s) will also terminate.

Please read the statement below, circle the benefit you wish to terminate and sign below to acknowledge your understanding. Return the signed form to eb@okc.gov or mail to our office at the address listed above.

Coverage will be terminated effective ________________.

Please indicate type(s) of coverage to be terminated:

- ❍ **Medical**
- ❍ **Dental**
- ❍ **Vision**
- ❍ **Retiree Life**

Terminate coverage for of all person(s) to have coverage terminated including yourself:

____

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I understand that if I indicate above to choose to terminate my medical, dental, vision and/or retiree life insurance coverage as a retiree with the City of Oklahoma City, I will not be allowed to re-enroll in the City's medical, dental, vision and/or retiree life insurance plan that is indicated above at a later date.

Signature Date

Please feel free to contact our office at 405-297-2144 if you have any questions.

Sincerely,

City of Oklahoma City
HR Department – Employee Benefits Division

Office Use Only: **Benefit Participation Screen Entry**

Medical	*Life Insurance*	*ACA Eligibility*		
NM(Field 2)____	NL(Field 3)____	Excluded______	Entered By______	Date______