

Medical/Dental Plan Cancellation Form

1. SUBSCRIBER INFORMATION			
Last Name	First Name	Middle Name	
Social Security Number	Gender	Cancellation Effective Month	
Street Address	City	State	Zip Code
Email Address		Daytime Phone Number	

2. CANCEL MY LACERS RETIRED MEDICAL/DENTAL PLANS AS INDICATED BELOW:
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Medical Plans
<input type="checkbox"/> Anthem Blue Cross PPO/Life & Health (Medicare Supplement)
<input type="checkbox"/> Anthem Blue Cross HMO - CA
<input type="checkbox"/> Kaiser Permanente/Senior Advantage – CA 225576-0
SCAN Health Plan: <input type="checkbox"/> CA
<input type="checkbox"/> UnitedHealthcare Medicare Advantage HMO - CA
UnitedHealthcare Medicare Advantage HMO: <input type="checkbox"/> AZ <input type="checkbox"/> NV (check one)
Dual Care HMO Medical Plans
<input type="checkbox"/> SCAN Health Plan/Anthem Blue Cross HMO - CA
<input type="checkbox"/> UnitedHealthcare Medicare Advantage HMO/Anthem Blue Cross HMO - CA
Dental Plans
<input type="checkbox"/> Delta Dental PPO SM - 17228
<input type="checkbox"/> DeltaCare [®] USA HMO - 76992 for ____ CA 00001 or ____ parts of NV only 00003

Consolidated Omnibus Budget Reconciliation Act (COBRA)

My covered dependent(s) and I are covered by another medical and/or dental plan; therefore, I do NOT want COBRA continuation.

Signature _____
Date

FOR OFFICE USE ONLY			
INITIALS	MOU	EFFECTIVE DATE	RETIREMENT ROLL DATE:

ADA NOTICE

As a covered entity under Title II of the Americans with Disabilities Act, the City of Los Angeles does not discriminate on the basis of disability and, upon request, will provide reasonable accommodations to ensure equal access to its programs, services and activities.