Termination of Coverage Request

Please be advised that I wish to terminate my coverage with:

Name of Plan: _____

Termination Date: _____

Reason: _____

Name: _____

Address: _____

_____

Phone Number: _____

Signature: _____ Date: _____

Please complete this form and return to:

Maria David, Employee Benefits

San Leandro Unified School District

San Leandro, CA 94577

For District use only:

Plan: _____

Group#: _____ Coverage Termination Date: _____