State of Rhode Island
DEPARTMENT OF ADMINISTRATION
Office of Employee Benefits
One Capitol Hill - 3rd Floor
Providence, RI 02908-5864
Phone: (401) 574-8530 | Fax: (401) 574-9281
Email: DOA.OEB@doa.ri.gov

RETIREE HEALTH CARE CANCELLATION FORM

INSTRUCTIONS: PLEASE PRINT OR TYPE IN BLACK INK

RETIREE INFORMATION (Must be completed in all cases)

RETIREE NAME: FIRST MIDDLE LAST

SOCIAL SECURITY NUMBER | TELEPHONE NUMBER (INCLUDE AREA CODE)

STREET ADDRESS OR PO BOX CITY STATE ZIP CODE

CANCELLATION OF HEALTH CARE

REASON FOR CANCELLATION: _____

_____

☐ CANCEL MY HEALTH CARE COVERAGE. EFFECTIVE DATE: _____

☐ CANCEL MY SPOUSE'S HEALTH CARE COVERAGE. EFFECTIVE DATE: _____

SPOUSE'S NAME: _____ SPOUSE'S SSN: _____

IF YOU ARE CANCELLING A SPOUSE'S COVERAGE BECAUSE OF HIS/HER DEATH, PLEASE ATTACH A COPY OF THE DEATH CERTIFICATE SO IT CAN BE FORWARDED TO THE MEDICAL INSURANCE PROVIDER.

NOTE: FORM MUST BE RECEIVED BY THE 1st OF THE MONTH TO CANCEL ON THE 1ST OF THE FOLLOWING MONTH.

FOR EXAMPLE:

IF FORM IS RECEIVED BY MARCH 1ST, THE EFFECTIVE DATE OF THE CANCELLATION WILL BE APRIL1ST.
IF FORM IS RECEIVED BY MARCH 2ND, THE EFFECTIVE DATE OF THE CANCELLATION WILL BE MAY 1ST.

SIGNATURE

RETIREE SIGNATURE: _____ DATE: _____

SPOUSE OF STATE RETIREE SIGNATURE, IF APPLICABLE: _____ DATE: _____

OFFICE OF EMPLOYEE BENEFITS

OFFICE USE ONLY

Accepted by: _____ Date Received: _____

Revised: October 2020