# Benefits Cancellation Form

Faculty & Staff

## Important Information

- **When to Use This Form** – Use this form to cancel your benefits and/or your dependent's benefits within 30 days of a qualifying event.
- **Complete the Form in its entirety** – This form will be returned to you if it is not filled in completely.
- **DEADLINE – Submit this form within 30 days of your qualifying event. Do not forget to sign this form because it cannot be processed without a signature.**

## Employee Information

First Name:_____ Middle Initial:_____ Last Name:_____

DU ID Number (Required):_____

Home Telephone:_____ Campus Telephone:_____

Email Address:_____

## Cancellation Reason

- **IRS Qualifying Event** **Date of Event**_____ **Effective Date of Cancellation**_____
  (mm/dd/yyyy) (mm/dd/yyyy)

You have 30 days from the date of the qualifying event to complete and return this form. Last day of coverage must be the last day of the month.

Type of Event:

- Marriage– I will be insured through my partner's employer benefits
- Divorce– Spouse/Partner is eligible for COBRA; please provide an address for your spouse/partner:_____
- My spouse/partner and/or child is eligible for insurance through his/her employer benefits.
- I have insurance through my new/second employer.
- I will be covered under my spouse/partner's employer plan
- My child is ineligible for benefits because he/she is age 26; child is eligible for COBRA. Provide an address for your child: to

  _____ _____
  (mm/dd/yyyy) (mm/dd/yyyy)

- Other:_____

## Section 1: Cancel Insurance Coverage

**Effective Date of Cancellation:** _____ (must be the last day of the month)
(mm/dd/yyyy)

| Check | Coverage | | Name: First, M.I., Last |
|---|---|---|---|
| • Remove | • Medical<br>• Dental<br>• Vision<br>FSA | • Voluntary Life<br>• Voluntary AD&D<br>• Critical Illness<br>Accidental | Employee (Myself) |
| • Remove | • Medical<br>• Dental<br>• Vision | • Voluntary Life<br>• VoluntaryAD&D<br>Critical Illness<br>Accidental | Spouse / Partner |
| • Remove | • Medical<br>• Dental<br>• Vision | • Voluntary Life<br>• Voluntary AD&D<br>Critical Illness<br>Accidental | Child |
| • Remove | • Medical<br>• Dental<br>• Vision | • Voluntary Life<br>• Voluntary AD&D<br>Critical Illness<br>Accidental | Child |
| • Remove | • Medical<br>• Dental<br>• Vision | • Voluntary Life<br>• VoluntaryAD&D<br>Critical Illness<br>Accidental | Child |
| • Remove | • Medical<br>• Dental<br>• Vision | • Voluntary Life<br>• Voluntary AD&D<br>Critical Illness<br>Accidental | Child |

## Section 2: Authorization and Signature – Sign and Date

_____

Signature (If using electronic signature, please return this form) Date

## How to Submit Your Cancellation Form

The preferred method is to complete this form electronically, and email it to:

Benefits@du.edu

By fax:

Attention:
Benefits, + X P D Q 5 H V R X U F H V
303-871-

Keep a copy of the fax transmission report with your form for your records.

In Person

Keep a copy for yourself and bring
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0.04 T55C < BT