

**Retiree Cancellation of Health and/or Dental Insurance**

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| --- | --- |
| **Retiree Name** |  |
| **Address** |  |
| **City** |  |
| **State**  |  | **ZIP** |  |  |  |
| **Date of Birth** |  |  |

|  |  |
| --- | --- |
| **Last Four Numbers of your Social Security Number** |  |

**Health Insurance**

🞏 I elect to cancel my **State of Iowa** retiree health insurance coverage for myself and my eligible dependents (if applicable).

**Effective Date of Cancellation:** \_\_\_\_\_\_\_\_\_ (must always be a first of the month)

(Example: if you put June 1, this would mean you have health insurance coverage through May 31.)

To cancel your MedicareBlueRx Iowa Plan, you must contact MedicareBlueRx at **877.838.3827** and request a disenrollment form. You cannot remain on the MedicareBlueRx Iowa Plan if you cancel your State of Iowa health insurance coverage.

**Dental Insurance**

🞏 I elect to cancel my **State of Iowa** retiree dental insurance coverage for myself and my eligible dependents (if applicable).

**Effective Date of Cancellation:** \_\_\_\_\_\_\_\_\_ (must always be a first of the month)

(Example: if you put June 1, this would mean you have dental insurance coverage through May 31.)

**I understand by cancelling State of Iowa retiree health and/or dental insurance coverage that I will not be eligible for rejoining the group at a later date.**

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Retiree Signature | Date |

Return this form to:

 Retiree Health and Dental Benefits

 Iowa Department of Administrative Services

 Human Resources Enterprise

 Hoover State Office Building, Level A

 1305 E. Walnut Street

Des Moines, IA 50319