Retiree Cancellation of Health and/or Dental Insurance

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 Iowa Group MedicareBlueRx ($5/$10/20%/45%/33%)plan, you must contact Group MedicareBlueRx at **877-838-3827** and request a voluntary 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