Revised 1/17

FOR CCC USE ONLY

Date: _____

Initials: _____

CULLMAN COUNTY COMMISSION HEALTH INSURANCE
2017 CANCELLATION FORM

SUBSCRIBER INFORMATION (Please print or type.)

Name (First, Middle Initial, Last)	Date of Birth

Social Security Number	Contract Number

CANCEL ALL INSURANCE COVERAGE FOR THE FOLLOWING REASONS:

_____ Voluntary Termination _____
Last Day in Pay Status

_____ Involuntary Termination _____
Last Day in Pay Status

_____ Retirement Date _____

_____Retiree Non-Payment_____COBRA **will not** be offered.

_____ Military Leave Date_____Attach military papers.

_____ Death _____

_____ Leave Without Pay - non-payment _____

_____Other Date_____Give explanation: _____

_____ Declination of Coverage. (You MUST complete and submit a "Declination of Coverage" form.)

Note: By submitting this Cancellation Form, health insurance coverage will be terminated.

TO BE COMPLETED BY EMPLOYER

Effective Date of Cancellation:_____

Notes: _____

_____

_____

_____

AFFIRMATION AND RELEASE

I hereby affirm that I have completely read and fully understand the terms and conditions of this form. I attest that all the representations made by me on this form are true and correct. I understand that any misrepresentation may result in the forfeiture of insurance coverage and that I will be personally liable for all claims related to such misrepresentation. I further understand that there is mandatory utilization review and I do hereby give permission to release any information necessary to evaluate, administer, and process claims for benefits to any person, entity or representative acting on the Cullman Co. Comm.'s behalf.

_____

Employee Signature Date

CULLMAN COUNTY COMMISSION
PERSONNEL DEPARTMENT
500 2ND AVENUE SW, ROOM 107
CULLMAN, AL 35055

(256) 775-4884 | (256) 775-4879 | FAX: (256) 739-3525