University of Denver
Human Resources
MEMORANDUM

TO: Human Resources - Office of Total Rewards

FROM: _____ Banner ID _____

SUBJECT: Cancellation of Insurance

DATE: _____

Please Cancel the Following Insurance:

_____ Health_____ Dental_____ Vision _____ Vol. Life _____ Vol. AD&D _____ FSA

For:

_____ Myself _____ My Dependent _____ Myself and Dependent(s)

List name(s) of member(s) to be cancelled: _____

_____

Effective Date of Cancellation (must be last day of month): _____/_____/_____

Reason for Cancellation (**Documentation needs to be submitted with this form)**

_____ Divorce** (spouse/partner is eligible for COBRA*)

_____ Marriage**I will now be insured through my spouse's employer

_____ My spouse/partner has a new job and is now eligible for insurance there**

_____ I have insurance with my new/second employer**

_____ I will be covered under my spouse/partner's employer plan**

_____ My child is no longer a dependent (child is eligible for COBRA*)

_____ I am taking a Leave of Absence from (dates) :_____ - _____

_____ Other: _____

**My spouse/dependent is eligible for COBRA coverage, please send COBRA information to:*

_____

_____

_____

Signature Phone Number Date