

2010 CANCELLATION FORM LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM SOUTHLAND NATIONAL VOLUNTARY INSURANCE

SUBSCRIBER INFORMATION

Name (First, Middle Initial, Last)	Sex	Date of Birth
Social Security Number	Contract Number	

CANCEL INSURANCE COVERAGE:
(Enrollment minimum of 12 months required without qualifying status change.)

Dental
 Vision
 Dental and Vision

TO BE COMPLETED BY EMPLOYER	AFFIRMATION AND RELEASE
<p>Effective Date of Cancellation:</p> <p style="margin-left: 40px;">_____/_____/_____</p> <hr style="border: 0; border-top: 1px solid black; margin: 10px 0;"/> <p style="text-align: center;">Local Government Unit Name</p> <hr style="border: 0; border-top: 1px solid black; margin: 10px 0;"/> <p style="text-align: center;">Account Number</p> <hr style="border: 0; border-top: 1px solid black; margin: 10px 0;"/> <p>Signature of Insurance Clerk Date</p>	<p style="text-align: center;">AFFIRMATION AND RELEASE</p> <p>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 SEIB's behalf.</p> <hr style="border: 0; border-top: 1px solid black; margin: 10px 0;"/> <p>Employee Signature Date</p>

* A "qualifying event" is birth, marriage, adoption, death, divorce, or otherwise losing dependent status.

STATE EMPLOYEES' INSURANCE BOARD
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