

Notice to Discontinue Health Care Coverage

Employee Name: \_\_\_\_\_ EIN: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

**Please read carefully and sign below**

I wish to discontinue my health care coverage. I realize that by discontinuing my coverage with the City's group health care plan **I will not be eligible to rejoin the City's group health care at any future date.** I also understand that I will receive a package from the City's Human Resources Office offering COBRA and that I may choose to participate in the plan.

\_\_\_\_\_  
Retiree

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date