DELETE DEPENDENT

EMPLOYEE:_____ ASSOCIATION:_____

Qualifying Event (Please check one):

☐ Divorce or Dissolution of Domestic Partnership* (Date:_____)
☐ Gains other coverage through spouse's or partner's employer (Date:_____)
☐ Other*: _____ (Date:_____)
**Please attach supporting documentation such as dissolution paperwork, etc.*

Delete Dependent:

1. Name of Dependent:_____
   Relationship:_____
   Delete from (please check all that apply): ❒ Medical ❒ Dental ❒ Vision

2. Name of Dependent:_____
   Relationship:_____
   Delete from (please check all that apply): ❒ Medical ❒ Dental ❒ Vision

3. Name of Dependent:_____
   Relationship:_____
   Delete from (please check all that apply): ❒ Medical ❒ Dental ❒ Vision

Name Changes

If you have a name change, you must submit a copy of your social security card (indicating the new name) and complete an Employee Address and Name Change form.

Beneficiary Changes

If you would like to change your beneficiary designations for the following plans, please check the appropriate boxes and the appropriate forms will be requested and sent to you through interoffice mail.

❒ CalPERS (retirement)
❒ Last Checks/Warrants Beneficiary
❒ Standard Insurance (Life, AD&D, optional life)
❒ Emergency Contact Information

Cobra Information

Information on continuation of health coverage must be sent to dependents who are being deleted from your health plans due to divorce or dissolution of partnership. Please indicate the address to which this information should be sent: _____

_____

_____ _____

Employee Signature Date