

RETIREE REQUEST FOR DISENROLLMENT

Clear Form

Effective Date: _____

PLEASE PRINT CLEARLY

Changes will be effective on the 1st of the month following receipt by Kern County Health & Wellness

RETIREE/RETIREE BENEFICIARY LAST NAME		FIRST NAME		DATE OF BIRTH	SOCIAL SECURITY NO	
ADDRESS			CITY	STATE	ZIP	
TELEPHONE	EMAIL			MEDICARE ID NO (if applicable)		

- ☐ **I wish to disenroll**
(to disenroll Retiree/Retiree Beneficiary and Dependents if applicable)

☐ **Disenrollment for dependent only**
(does not apply to Retiree/Retiree Beneficiary)

From the following health plan(s):

(mark boxes in this section that apply to the Retiree/Retiree Beneficiary)

- ☐ Kern Legacy Classic Choice

☐ Blue Cross Gold w/RX

☐ Health Net COB POS

☐ Kern Legacy Max Choice

☐ Blue Cross Silver

☐ Health Net Seniority Plus

☐ Kern Legacy Network Plus

☐ Blue Cross Medicare PPO

☐ Liberty Dental HMO (CA40-R Plus)

☐ Kern Legacy Share Select

☐ Blue Shield 65 Plus

☐ Vision Service Plan (VSP)

☐ Kaiser Under 65

☐ Kaiser Senior Advantage

List all dependents that you are disenrolling:

(if the Retiree/Retiree Beneficiary is disenrolling, all dependents will also be disenrolled)

DEPENDENT'S LAST NAME	FIRST NAME	DATE OF BIRTH	SOCIAL SECURITY/MEDICARE ID NO
DEPENDENT'S LAST NAME	FIRST NAME	DATE OF BIRTH	SOCIAL SECURITY/MEDICARE ID NO
DEPENDENT'S LAST NAME	FIRST NAME	DATE OF BIRTH	SOCIAL SECURITY/MEDICARE ID NO

From the following health plan(s):

(mark boxes in this section that apply to the dependents listed above)

- ☐ Kern Legacy Classic Choice

☐ Blue Cross Gold w/RX

☐ Health Net COB POS

☐ Kern Legacy Max Choice

☐ Blue Cross Silver

☐ Health Net Seniority Plus

☐ Kern Legacy Network Plus

☐ Blue Cross Medicare PPO

☐ Liberty Dental HMO (CA40-R Plus)

☐ Kern Legacy Share Select

☐ Blue Shield 65 Plus

☐ Vision Service Plan (VSP)

☐ Kaiser Under 65

☐ Kaiser Senior Advantage

I understand that my dependents lose eligibility to participate in the County retiree health plans on the same effective date that my coverage is canceled. I also understand that I lose eligibility for the County Stipend, if I cancel ALL insurance coverage through the County of Kern. If I decide to re-enroll in a County health program at any time in the future, I will not be eligible to receive the County Stipend until I have been re-enrolled for at least 3 years. This does not apply if I am simply transferring between County plans (disenrolling from one County plan while enrolling in a different County plan with a permitting event).

Return completed form to:

Kern County Health & Wellness
1115 Truxtun Ave, 1st Floor
Bakersfield, CA 93301

For questions, call (661) 868-3182.

Retiree/Retiree Beneficiary's Signature

Date

Spouse's Signature (required if disenrolling from a Medicare plan)

Date