

Return completed form to Kern County Health & Wellness by 5:00 p.m. on Friday, November 6, 2026

Clear Form

Effective Date: 01/01/2027

1. RETIREE/RETIREE BENEFICIARY INFORMATION

LAST NAME	FIRST NAME	SSN OR SYSTEM ID
STREET ADDRESS, APT. OR SUITE NO., CITY, STATE, ZIP CODE		DATE OF BIRTH
TELEPHONE NUMBER	EMAIL	MEDICARE ID (if applicable)

2. WHO ARE YOU DISENROLLING? (Check One)

- | | |
|---|---|
| ☐ Retiree/Retiree Beneficiary (Self)
All covered dependents will also be disenrolled | ☐ Dependent(s) Only
The Retiree/Retiree Beneficiary will remain enrolled |
|---|---|

3. PLAN COVERAGE TO CANCEL: Complete ONLY if disenrolling Retiree/Retiree Beneficiary and ALL Dependents if applicable.
 (check ALL boxes in this section that apply)

- | | | |
|---|--|---|
| ☐ 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 | |

4. LIST ALL DEPENDENTS THAT YOU ARE DISENROLLING: Complete ONLY if disenrolling Dependents.
 (if the Retiree/Retiree Beneficiary is disenrolling, all dependents will also be disenrolled)

LAST NAME	FIRST NAME	DATE OF BIRTH	SSN OR MEDICARE ID
LAST NAME	FIRST NAME	DATE OF BIRTH	SSN OR MEDICARE ID
LAST NAME	FIRST NAME	DATE OF BIRTH	SSN OR MEDICARE ID

5. DEPENDENT PLAN COVERAGE TO CANCEL: Complete if disenrolling ONLY Dependents, NOT Retiree/Retiree Beneficiary.
 (check ALL boxes in this section that apply)

- | | | |
|---|--|---|
| ☐ 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 form to:

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

Retiree/Retiree Beneficiary's Signature

Date

For questions, call (661) 868-3182.

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

Date