

Dental Insurance Cancellation Form

Complete the form below if you would like to cancel your current policy

- to cancel your existing plan, complete and mail only this form

Do not mail this form to the dental insurance company. Please mail to:

AFSCME Council 24
Attn: Dental Insurance Department
8033 Excelsior Drive, Suite C
Madison, WI 53717

Name (please print): _____

Worksite: _____

Social Security number: _____

Insurance plan you would like to cancel (2009 monthly premiums appear in parentheses):

- Delta Dental, Exclusive Provider (**PPO**) (\$27.28, \$53.87, \$102.98)
- Delta Dental, Delta Preferred (\$29.85, \$58.83, \$111.09)
- Care Plus, Care Plus Prepaid Dental Plan (\$30.50, \$74.96)

Signature: _____

Date Signed: _____

For office use only

Payroll number: _____

Date processed: _____

Effective date: _____