YCCD Benefits Office

Request for Termination/Continuation of Coverage

✓ **Check as appropriate.** **Due by the 15th prior to the month of termination.**

I understand that by terminating district coverage and the individual retiree plan coverage offered through SISC, I give up my right to enroll in any SISC coverage at any subsequent date. I also understand that this decision is irrevocable. ***Initial:*** _____

❑ **I wish to terminate the following insurance plan(s) effective the last day of the month**

of: _____. Check all that apply:
Month / Year

❑ **Medical** ❑ **Dental** ❑ **Vision**

❑ **I wish to continue the following health insurance coverage and understand the following:**

- Premiums are due the first of each month. Failure to make timely premium payment will result in coverage cancellation without notice.
- Cancellation must be received in Benefits at least 15 days prior to the first of the month.
- I will advise the District of any status or address change.
- Premiums are subject to change annually.
- Payment should be made payable to "YCCD" and sent to YCCD Controller's Office, P.O. Box 4065, Modesto, CA 95352
- I understand if I leave the District's health group plan, I am not eligible to re-enroll.

Please check all that apply:

❑ **Medical** ❑ **Dental** ❑ **Vision**

Note - If continuing any coverages, monthly premiums will still be due to the 1st of each month.

_____ _____
Signature Date

_____ _____
Print Name Phone No.

_____ _____ _____ _____
Address City State Zip

☎ Questions?

- Regarding receipt or deposit of payment, please contact the **Controller's Office at (209) 575-6588.**
- Regarding premium amount or plan benefits - please continue to contact the Benefits Office at (209) 575-6547.

YCCD Benefits Office: P O BOX 4065 Modesto, CA 95352 / Fax: (209) 575-6969

psf rev 07/19/18