Today's Date: _____

Please cancel the following group health insurance coverages with the Public School Retirement System effective _____.

- ☐ Medical
- ☐ Dental
- ☐ Vision

I understand that I must have a qualifying event in order to obtain future coverage through the Public School Retirement System (i.e., Loss of coverage through no fault of my own; or Medicare-eligibility [medical only]).

Print Name _____

Signature _____

SSN _____