Holston Conference UMC Health Insurance
CANCELLATION of Health Insurance Form

Church/Organization: _____

A. Employee Data (*please print*)

_____ Employee Blue Cross Blue Shield 9-Digit ID Number

_____ Employee Social Security Number

Effective Date _____

_____ Employee Name (Last, First, M.I.)

_____ Home Phone with Area Code

_____ Home Address (Street, City, State, Zip)

_____ Work Phone with Area Code

B. Type of Coverage Being CANCELLED

☐ Health ☐ Vision ☐ Dental

☐ Cancel All Coverage (employee & Dependents)

☐ Cancel All Dependent Coverage Only

☐ Cancel Coverage **only on the dependent(s)** listed below in Section C

Reason for Cancellation:

☐ Left Employment
☐ Retired
☐ Reduction of Work Hours
☐ Marriage
☐ Subscriber Requested
☐ Death
☐ Group Continuation (COBRA) Period Expired
☐ Divorce
☐ Covered Under Spouse's Policy *(proof of insurance required for full time clergy)*

C. LIST ALL INDIVIDUALS TO BE CANCELLED – COMPLETE ALL THAT APPLY (use extra paper if necessary)

Last Name/First Name/Middle Initial

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*I understand and agree that I am cancelling coverage in the **Holston Conference Self-Insured Health Plan** administered by Blue Cross/Blue Shield of Tennessee as indicated above, and that my signature on this form will terminate insurance through Blue Cross/Blue Shield of Tennessee of any individual(s) listed.*

Employee Signature: _____ Date Signed: _____

Questions? email: openenrollment@holston.org or visit www.holston.org/openenrollment

Please send completed form to the Holston Conference Benefits Office by emailing it to ***openenrollment@holston.org***
or mailing it to **Holston Annual Conference, Attn: Insurance Cancellation, P.O. Box 850, Alcoa, TN, 37701**.