THE UNIVERSITY OF CHICAGO | HUMAN RESOURCES

RETIREE MEDICAL PLAN CANCELATION FORM

By my signature below, I acknowledge that I **do not** wish to participate in The University of Chicago Retiree Medical Plan.

Termination

I am terminating my enrollment in the Retiree Medical Plan effective: _____

Acknowledgement

I acknowledge that:

- ☐ By electing to terminate enrollment in the Retiree Medical Plan, my medical and prescription drug coverage will end.
- ☐ I cannot reinstate my enrollment in the University of Chicago Retiree Medical Plan at a later date.

Subscriber Information

Retiree Name: _____ SSN: XXX-XX-_____
Please print

Covered Dependent: _____
Please print

Covered Dependent: _____
Please print

Signature

_____ _____
Retiree Signature Date

Contact Information

Phone Number: _____

Email Address: _____

Submit Form

Please return this signed form to retiree@uchicago.edu or fax to (773)834-0996. You can also mail the form to:

The University of Chicago
Attention: Benefits Office
6054 S. Drexel Avenue
Chicago, IL 60637