THE UNIVERSITY OF BRITISH COLUMBIA

MEDICAL/DENTAL CANCELLATION FORM

Personal information provided on this form is collected pursuant to section 26(c) of the *Freedom of Information and Protection of Privacy Act,* RSBC 1996, c. 165. The information will be used for the purpose of benefits administration, claims submission and to make any necessary payroll deductions. For further information, please email benefitsinfo@hr.ubc.ca.

Name of Employee (first name, last name)	Employee Identification Number	Department	Faculty ☐ Staff ☐

Check only those that apply:

☐ I wish to cancel my Medical Services Plan (MSP) through UBC effective (**date must be month end date**)_____.

☐ I wish to cancel my Extended Health* coverage through UBC effective (**date must be month end date)**_____.

☐ I wish to cancel my Dental* coverage through UBC effective (**date must be month end date)**_____.

* Please be advised that the UBC plan allows members to have coverage under more than one Plan (ie. members may also be covered under a spouse or partner's Plan). If your spouse or partner's Plan does not allow for dual coverage, you must decide which plan best meets your needs and enroll/cancel accordingly.

_____

Signature

_____

Date