



Human Resources

613 East Broadway, Room 100
Glendale, California 91206-4392
(818) 548-2110
www.glendalca.gov

City of Glendale
Benefit Declination/Termination of Coverage Form

Name: _____

- New Hire Active Employee Retiree

Employee ID No: _____

Social Security: _____

Date Of Birth: _____

Phone Number: _____

Email Address: _____

Division: _____

Declination/Termination of Coverage:

I have been offered the opportunity of participating in the City of Glendale’s health insurance program and have chosen to decline/terminate the following plans:

- Medical
- Dental
- Vision

My reason is:

- Cost
- Other Group Coverage
- Other: _____

Please discontinue my coverage with the following effective date: _____

(Note: Effective date must be the 1st of the designated month (cannot be retroactive).)

Signature

Date

Form can be scanned and emailed to Benefits@glendaleca.gov or faxed to (818) 243-8428.