CITY OF GLENDALE, CALIFORNIA
Human Resources
Civil Service Commission

613 E. Broadway, Suite 100
Glendale, CA 91206-4308
Tel. (818) 548-2110
glendaleca.gov

Benefit Declination/Termination of Coverage Form

Name: _____

☐ New Hire ☐ Active Employee ☐ Retiree

Employee ID: _____

Social Security: _____

Date Of Birth: _____

Phone Number: _____

Email Address: _____

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
- ☐ Supplemental or Retiree Life

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.