



HEALTH INSURANCE COVERAGE CANCELLATION FORM

I am presently enrolled in the Health Insurance Program with Rosalind Franklin University of Medicine and Science.

I have adequate hospitalization and major medical insurance with another health insurance carrier as indicated below and wish to discontinue coverage with the University.

I wish to discontinue my coverage effective : \_\_\_\_\_  
(First of Month)

\_\_\_\_\_  
(Print Name)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Sign)

\* \_\_\_\_\_  
(New Insurance Carrier's Name)

\* \_\_\_\_\_  
(New Policy Number)

\*Required to discontinue coverage.