## Benefit Services

New Mexico State University

MSC 3HRS, Box 30001

Las Cruces, NM 88003-8001

Phone: (575) 646-8000

Fax: (575) 646-2806

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**Retiree Medical/Life Discontinuance Form**

Cancellation of benefits will be the first of the month after the completed form is received by the Benefit Services department. Retirees on the NMSU PPO medical plan can cancel at any time. Retirees on the NMSU Medicare Carve-Out plan can only cancel once a year during the annual enrollment period for Medicare. Cancellations for MCO members will be effective January 1st. Retirees cancelling due to the enrollment in a non-NMSU Medicare Part D plan will have cancellation of benefits effective the first of the month in which the new Medicare Part D plan becomes effective.

|  |  |  |
| --- | --- | --- |
| **Retiree Information** | | |
| Name (Last, First, Middle Initial) | Banner ID | SSN (if Banner # is unknown) |
| Street Address | City, State, Zip | Daytime Phone # (xxx-xxx-xxxx) |

**Please check all that apply:**

Please cancel medical plan coverage for the individuals listed below

Please cancel my life insurance

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **DEPENDENT INFORMATION – List only those participants you wish to cancel** | | | | | | |
|  | Last Name | First Name | MI | Social Security # | Birth Date | Gender |
| Self |  |  |  |  |  | Male  Female |
| Spouse |  |  |  |  |  | Male  Female |
| Domestic Partner |  |  |  |  |  | Male  Female |
| Dependent |  |  |  |  |  | Male  Female |
| Dependent |  |  |  |  |  | Male  Female |
| Dependent |  |  |  |  |  | Male  Female |
| Dependent |  |  |  |  |  | Male  Female |

|  |
| --- |
| I certify that I wish to cancel my coverage. I understand that I will not be able to enroll in the NMSU Retiree coverage in the future. |
| Signature Date |  |

**For Use by HR Benefits/Payroll Office**

|  |  |  |  |
| --- | --- | --- | --- |
| HR Code: | Effective Date: | Input Date: | Initials: |