Revised
4/9/2025

CULLMAN COUNTY COMMISSION HEALTH INSURANCE CANCELLATION FORM

FOR CCC USE ONLY

Date: _____

Initials: _____

SUBSCRIBER INFORMATION (Please print or type.)

Name (First, Middle Initial, Last)	Date of Birth

Social Security Number	Contract Number

CANCEL ALL INSURANCE COVERAGE FOR THE FOLLOWING REASONS:

_____ Voluntary Termination _____
Last Day in Pay Status

_____ Involuntary Termination _____
Last Day in Pay Status

_____ Retirement Date _____

_____Retiree Non-Payment_____COBRA **will not** be offered.

_____ Military Leave Date_____Attach military papers.

_____ Death _____

_____ Leave Without Pay - non-payment _____

_____Other Date_____Give explanation: _____

_____ Voluntary Declination of Coverage. Reason: _____

Note: By submitting this Cancellation Form, health insurance coverage will be terminated.

TO BE COMPLETED BY EMPLOYER

Effective Date of Cancellation:_____

Notes:_____

_____

_____

Payroll Deduction Changed To: _____

_____

AFFIRMATION AND RELEASE

I hereby affirm that I have completely read and fully understand the terms and conditions of this form. I attest that all the representations made by me on this form are true and correct. I understand that any misrepresentation may result in the forfeiture of insurance coverage and that I will be personally liable for all claims related to such misrepresentation. I further understand that there is mandatory utilization review and I do hereby give permission to release any information necessary to evaluate, administer, and process claims for benefits to any person, entity or representative acting on the Cullman Co. Comm.'s behalf.

_____

Employee Signature Date

CULLMAN COUNTY COMMISSION
PERSONNEL DEPARTMENT
500 2ND AVENUE SW, ROOM 107
CULLMAN, AL 35055

(256) 775-4884 | (256) 775-4879 | FAX: (256) 739-3525