Discontinue Coverage for Family Members

King County
Benefits, Payroll and Retirement Operations

- Submit this form **within 30 days after the qualifying event** (or sooner) to Benefits, Payroll and Retirement Operations, The Chinook Building CNK-ES-0240, 401 Fifth Ave., Seattle 98104-2333, or fax it to 206-296-7700.
- To remove coverage for a child, spouse, or domestic partner, submit one form for each covered family member.
- If you would like to discontinue some, but not all, benefit coverage for a family member (for example, remove health coverage but keep life insurance coverage, if they remain eligible), indicate the specific coverage you would like to discontinue, otherwise, we will discontinue all coverage for this person.
- If there is a divorce or dissolution of a domestic partnership, you must remove coverage for the former spouse or domestic partner using this form and a copy of the divorce decree **within 30 days**. Continuation of health benefits lost due to divorce or dissolution of a domestic partnership is only available under COBRA once the divorce/dissolution is final.
- You might also want to submit new county insurance, state retirement and deferred compensation beneficiary designation forms.
- Questions? Go to kingcounty.gov/benefits, e-mail kc.benefits@kingcounty.gov, or call 206-684-1556.

Provide information about the family member for whom you're discontinuing coverage

Event prompting change
- ☐ Death
- ☐ Divorce (attach divorce decree)
- ☐ Domestic partnership ended
- ☐ Separation (you must notify Benefits, Payroll and Retirement operations when a divorce is final)
- ☐ Qualified Medical Child Support Order ended (attach copy)
- ☐ I self-pay to cover this family member and opt not to continue
- ☐ Child no longer eligible
- ☐ Other (explain) _____

Date event occurred _____

Family member's name _____ Birth date _____

Mailing address for COBRA notification (required if living at a different address than yours)

Street _____ Apt No _____

City _____ State _____ ZIP _____

Coverage you would like to discontinue

Please indicate the coverage you would like to discontinue for the person listed above. If you do not indicate specific coverage, we will discontinue all coverage for the person listed.

☐ I would like to discontinue all coverage for the person listed above.

I would like to discontinue only the following coverage for the person listed above:

- ☐ Medical
- ☐ Dental
- ☐ Vision
- ☐ Supplemental life
- ☐ Supplemental accidental death and dismemberment (AD&D)

Authorize your change

This information is true, correct and complete, and amends previously submitted information. I authorize King County to make any payroll deductions or refunds resulting from my requested change. I understand the willful falsification of any information I have provided may lead to disciplinary action up to and including discharge from employment.

Employee signature _____ Date signed _____

Printed name _____ Contact phone _____

Paid ☐ 5th and 20th ea month ☐ Every other Thursday Employee ID _____

Office use only	Date received	Processed by	Audited by	Date effective