Suspension of Health Coverage

If you are covered under the CCPF Health Plan, you may elect to suspend your coverage at any time. Enrollment for any covered dependents automatically terminates when you elect to suspend coverage. Your completed Suspension of Health Coverage form must be received by the 15th day of the month for coverage termination to be effective on the first day of the following month.

If you suspend coverage, you may only re-enroll during the annual open enrollment period in November for coverage to begin January 1 of the following year.

However, if after you suspend CCPF health coverage you obtain other health coverage through an employer, or a spouse's employer, you may re-enroll in the CCPF Health Plan within 30 days of your employer coverage ending. Your application for re-enrollment in the CCPF Health Plan must be submitted to CCPF by the 15th day of the month for coverage to begin on the first day of the following month. You may be required to present documentation proving the start and end dates of your employer coverage.

I hereby elect to suspend my enrollment in the CCPF Health Plan for:

□ Myself

□ All my dependents covered in the CCPF Health Plan

□ Only Listed Dependent(s):

Dependent Name _____

Dependent Name _____

Dependent Name _____

I understand that any bills for services after the date coverage ends will be denied *and* reimbursement to the insurance carrier may be necessary.

Name:
Signature: Date:
Social Security Number:
Date Suspension of Benefits to Begin:

FOR OFFICE USE ONLY:

Office#_____ Effective Date _____

County Employees' and Officers' Annuity and Benefit Fund of Cook County
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