



# THE UNIVERSITY OF BRITISH COLUMBIA

## MEDICAL/DENTAL CANCELLATION FORM

Personal information provided on this form is collected pursuant to section 26(c) of the *Freedom of Information and Protection of Privacy Act*, RSB 1996, c. 165. The information will be used for the purpose of benefits administration, claims submission and to make any necessary payroll deductions. For further information, please email [benefitsinfo@hr.ubc.ca](mailto:benefitsinfo@hr.ubc.ca).

Name of Employee (first name, last name)	Employee Identification Number	Department	Faculty <input type="checkbox"/>
			Staff <input type="checkbox"/>

Check only those that apply:

I wish to cancel my Medical Services Plan (MSP) through UBC effective (**date must be month end date: m/d/yr**)

MSP Care Card Number

I wish to cancel my Extended Health\* coverage through UBC effective (**date must be month end date: m/d/yr**)

I wish to cancel my Dental\* coverage through UBC effective (**date must be month end date: m/d/yr**)

\* Please be advised that the UBC plan allows members to have coverage under more than one Plan (ie. members may also be covered under a spouse or partner's Plan). If your spouse or partner's Plan does not allow for dual coverage, you must decide which plan best meets your needs and enroll/cancel accordingly.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Return form with handwritten signature to:**

Payroll  
Finance Operations, UBC's Okanagan campus  
EME 2171 - 1137 Alumni Avenue  
Kelowna, BC  
CANADA  
V1V 1V7