**Springfield Public Schools**
**Human Resources & Benefits Department**

***We exist for the academic excellence of all students.***

# RETIREMENT DROP FORM

| EMPLOYEE LAST NAME | FIRST NAME | SOCIAL SECURITY NUMBER |
|---|---|---|
| | | |
| **ADDRESS** | **CITY/STATE/ZIP** | **HOME PHONE NUMBER** |
| | | |

**COVERAGE CHANGE:** Please stop **□Medical □ Dental □ Vision**

for the following people effective the last day of _____, _____.

(Month) (Year)

| | | FULL NAME | RELATIONSHIP | DATE OF BIRTH |
|---|---|---|---|---|
| | | | | |
| | | | | |

| **REASON FOR CHANGE:** **(Verification Required)** | |
|---|---|

**My new coverage will be:**

☐ Employee Only ☐ Employee and Spouse

☐ Employee and **One** Child ☐ Employee and Two or more Children

☐ Employee and Family

I understand this form must be returned to the SPS Benefits Office within 30 days of the date of change. Coverage and premiums will end on the last day of the current month. I further understand that once I terminate my coverage, I no longer am eligible to elect the coverage again.

_____ _____

Signature Date

| FOR USE BY BENEFITS OFFICE ONLY | | | | | |
|---|---|---|---|---|---|
| COVERAGE TERM DATE | SYSTEM UPDATE | COBRA SENT | CCC SENT | MP NOTIFY | REFUND |
| | | | | | |

Rev: 11/11

**1359 E. St Louis St.♦Springfield, Missouri 65802**
**(417) 523-4647♦Fax (417) 523-0194**