CRANSTON PUBLIC SCHOOLS
CANCELLATION OF HEALTH/DENTAL COVERAGE

I, _____ would like to

cancel my:

_____ Health coverage

_____ Dental coverage

effective _____.
(The first of the month)

The Cranston School Department will not be responsible for any claims incurred by me or my dependent(s) from the date indicated above.

_____
Print Name

_____ _____
Signature Date

_____ _____
Notary Signature Date

Seal:

Office:
_____Deduction(s) removed

_____Coverage(s) cancelled

Return this form to Human Resources/Benefits.