SFIHSS PUBLIC AUTHORITY

CANCELLATION OF BENEFITS REQUEST FORM

832 Folsom Street, 9th Floor ▪ San Francisco, CA 94107

(415) 243-4477 ▪ benefits@sfihsspa.org ▪ www.sfihsspa.org

Name:	LAST	FIRST	M.I.
IHSS Provider Number:			
Social Security Number:			

I WOULD LIKE TO CANCEL THE FOLLOWING: *(Check all that apply)*	
☐ ***CANCEL***	**Health Insurance** *(SFHP Healthy Worker)*
☐ ***CANCEL***	**Dental Insurance** *(Liberty Dental EPO / LDP100)*

Signature:		**Date:**	

SUBMIT THIS FORM BY:	
EMAIL:	benefits@sfihsspa.org
MAIL:	IHSS Public Authority 832 Folsom St, 9th Floor San Francisco, CA 94107-1140 Attn: Benefits Department
FAX:	(415) 243-4407

- *If Cancellation of Benefits Request Form is received **before** the 12th of the month, termination date will be the last day of the current month.*
- *If Cancellation of Benefits Request Form is received **after** the 12th of the month, termination date will be the last day of the following month.*