LEGALLY DOMICILED ADULT DECERTIFICATION FORM

PLEASE RETURN FORM TO MCC AT 510 SOUTH CAPITOL AVENUE, LANSING MI, 48933
517-372-2911 (FAX) OR EMAIL TO BENEFITS@MICATHOLIC.ORG

Employee Information

Name:_____ Date of Birth:_____

☐ **I hereby elect to decertify the following Legally Domiciled Adult from benefits coverage. By doing so, I acknowledge that they will lose *all* of the benefits that they had been receiving as soon as administratively possible:**

Legally Domiciled Adult Information

Name:_____ Date of Birth:_____

Reason for decertification:

☐ **Change of eligibility due to gain or loss of coverage under another benefits policy**

☐ **Loss of dependent coverage due to death or other loss of eligibility**

☐ **Other (no further explanation is necessary)**

_____ _____
Employee Signature Date

_____ _____
Legally Domiciled Adult Signature (optional) Date

FOR MCC USE ONLY

De-certification received and approved by: _____