PARKWAY SCHOOL DISTRICT
MEDICAL/DENTAL/VISION INSURANCE
DROP FORM

Retiree Name ______________________________ SS#: XXX-XX-__________

Street Address ____

City ______________________________ State __________ Zip ____________

Phone ____________ Date of Birth ____________ E-Mail Address ____________________

Please list only the person(s) you wish to DROP and put X under which plan you want to DROP.

Relationship	Gender M/F	Last Name	First Name	Social Security Number (last 4 numbers)	Birth Date	Medical	Dental	Vision
SELF								
SPOUSE								
CHILD								
CHILD								
CHILD								

I hereby authorize Parkway School District to drop the above listed participants from the checked benefits above.

Retiree's Signature: ______________________________ Date: ________________

EFFECTIVE DATE OF DROP: ____________________

Please Note that Parkway drops benefits on the last day of the month in which we receive this form. If you have a direct debit setup with Parkway, we would need to receive this drop form 3 business days before the end of the month in which you are dropping in order to stop or change the direct debit amount.

Once completed and signed, please return this form to:

Parkway School District
Attn: Benefits
455 N. Woods Mill Rd.
Chesterfield, MO 63017

Or Fax to: (314) 415-8050 Or scan and email to: jbovaconti@parkwayschools.net