OFFICE OF PENSIONS
PENSIONER HEALTH BENEFIT TERMINATION FORM

Name: _____

SS# or Employee ID: _____

Coverage Code: _____

I wish to cancel my health insurance effective _____(date) from the Delaware Public Employees' Retirement System health plan administered by:

Circle company: Blue Cross Blue Shield of DE OR Aetna

_____
Signature

_____
Date

_____
Phone Number

By signing this form I understand that I can only re-enroll during the annual benefit re-opening period or within 30 days of a qualifying event.

Please return this form to the Office of Pensions by mail or by fax to the address or fax number below:

Office of Pensions
McArdle Building
860 Silver Lake Blvd., Ste 1
Dover, DE 19904-2402
FAX # - 302-739-6129