STATE OF DELAWARE
OFFICE OF PENSIONS

MEDICARE HEALTH PLAN WAIVER/TERMINATION

PLEASE COMPLETE AND RETURN FORM TO THE OFFICE OF PENSIONS

NAME:_____ PENSION ID OR SSN:_____

PENSION PLAN: (Check One)
☐ State Employees' ☐ New State Police ☐ County/Municipal Police
☐ Closed State Police ☐ County/Municipal General

TELEPHONE NUMBER: _____

I have been advised of my eligibility to enroll in the current State of Delaware health plan. I elect **not** to participate in this plan offered through the Office of Pensions. If enrolled in a healthcare insurance plan through the State of Delaware, my coverage **will terminate** upon becoming Medicare eligible. In waiving this coverage, I understand that I may not enroll until the next Open Enrollment period unless I experience an involuntary loss of coverage. I also understand that if I have a loss of coverage, I have 30 days to notify the Office of Pensions.

By signing this waiver, I understand my medical and prescription coverage will be terminated.

X_____ X_____

SIGNATURE **DATE**

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