STATE OF DELAWARE
OFFICE OF PENSIONS

MEDICARE HEALTH PLAN WAIVER/TERMINATION

PLEASE COMPLETE AND RETURN FORM TO PENSION.FORMS@DELAWARE.GOV

Pension ID or SSN: _____ Phone Number: _____

First Name & Middle Initial: _____Last Name: _____

Pension Plan: Check One

☐ State Employees'
☐ New State Police
☐ Closed State Police
☐ County Municipal General
☐ County Municipal Police and Fire

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.

Signature _____ Date _____

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