

STATE OF DELAWARE OFFICE OF PENSIONS

MEDICARE HEALTH PLAN WAIVER/TERMINATION

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

NAME:		PENSION ID OR S	SN:
PENSION PLAN: (Check One)	State Employees'	New State Police	County/Municipal Police
	Closed State Police	County/Municipal G	eneral
TELEPHONE NUMBE	CR:		
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 waiterminated.	iver, I understand my	medical and prescri	ption coverage will be
X	GNATURE	X	
SI	GNATURE		DATE