



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 SSN: _____

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

 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