HEALTH CARE COVERAGE: VOLUNTARY TERMINATION OF MEDICAL/PHARMACY COVERAGE

Ohio Public Employees Retirement System
277 East Town Street, Columbus, Ohio 43215-4642
1-800-222-PERS (7377)
www.opers.org

STEP 1: Personal Information

Member Social Security Number

Beneficiary Social Security Number
(Only if you are receiving a survivor benefit)

First Name | MI | Last Name

STEP 2: Voluntary Termination of Medical/Pharmacy Coverage

I do not want the OPERS group medical/pharmacy coverage. I wish to elect to voluntarily terminate any coverage under hospital, medical and prescription plans, including dependent group coverage as offered by OPERS. I have read the "Re-enrollment" section of the *OPERS Health Care Coverage Guide* and understand my rights regarding re-enrollment in the OPERS health care plan.

Recipient Signature | Date

STOP Sign above to terminate OPERS group coverage for all eligible recipients.

-- OR-- Skip to Step 3 to notify of ineligibility for your spouse. Skip to Step 4 to terminate OPERS group coverage for spouse. Skip to Step 5 to notify of death or to terminate OPERS group coverage for child(ren)

STEP 3: Notification of Spouse Ineligibility

◯ **Death** *(Please provide copy of death certificate. Originals will not be returned.)*

Date of Death

◯ **Marriage termination due to divorce, dissolution or annulment** *(Include a certified copy of your divorce, dissolution or annulment decree.)*

Date of Marriage Termination

◯ **Coverage through own retirement account with one of the Ohio Retirement Systems** *(Check applicable Ohio Retirement System.)*

◯ **Ohio PERS** ◯ **SERS** ◯ **STRS** ◯ **OP&F** ◯ **HPRS**

Account Number

STEP 4: Terminate OPERS Group Coverage for Spouse

◯ **Eligible Spouse - Voluntary Termination** *(OPERS group coverage terminated within 31 days of receipt of this form.)*

◯ **Other** *(Please explain.)*

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STEP 5: Notification of Death and/or Terminate OPERS Group Coverage for Child(ren)

Provide name and reason for terminating health care coverage for your child(ren). *(For additional children, please include a separate page.)*

1. Child's First Name MI Last Name

Reason for terminating health care coverage for child:

◯ **Death** *(Please provide copy of death certificate. Originals will not be returned.)*

Date of Death

/ /

◯ **Eligible Child - Voluntary Termination** *(OPERS group coverage terminated within 31 days of receipt of this form.)*

◯ **Other** *(Please explain.)*

_____

2. Child's First Name MI Last Name

Reason for terminating health care coverage for child:

◯ **Death** *(Please provide copy of death certificate. Originals will not be returned.)*

Date of Death

/ /

◯ **Eligible Child - Voluntary Termination** *(OPERS group coverage terminated within 31 days of receipt of this form.)*

◯ **Other** *(Please explain.)*

_____

Sign here to validate the ineligibility notification or termination of OPERS group coverage for spouse and/or child(ren):

Recipient Signature _____ Today's Date ____/____/____

Do not print or type name