*SCHOOL EMPLOYEES RETIREMENT SYSTEM OF OHIO*
300 E. BROAD ST., SUITE 100 • COLUMBUS, OHIO 43215-3746
614-222-5853 • Toll-Free 800-878-5853 • www.ohsers.org

# WAIVER AND CANCELLATION OF HEALTH CARE COVERAGE

I hereby waive and/or cancel any medical and prescription drug coverage provided by SERS.

**My dependent(s) and I understand that by waiving or cancelling SERS' health care coverage:**

- My dependents and I will not be entitled to coverage or payment for any expenses or claims incurred during any period in which this Waiver and Cancellation is or was in effect
- I will forfeit my Medicare Part B reimbursement, if applicable
- The waiver or cancellation is effective during my lifetime for me, my spouse, and my eligible children and can only be revoked by filing a health care enrollment application:
  - Within 90 days of becoming eligible for Medicare, or
  - Within 31 days of the involuntary termination of coverage under another plan or termination of Medicaid.

If you and your dependents are enrolled in dental and/or vision coverage, please indicate if you like to keep or cancel your coverage:

| **DENTAL COVERAGE** | **VISION COVERAGE** |
|---|---|
| ☐ Keep | ☐ Keep |
| ☐ Cancel | ☐ Cancel |
| ☐ Not applicable | ☐ Not applicable |

**Benefit Recipient Name**: _____ **Social Security Number:** _____

**Signature of Benefit Recipient**: _____

**Date**: _____

**Spouse Signature:** _____
(REQUIRED IF ENROLLED IN HEALTH CARE COVERAGE)

**Requested cancellation date of SERS health care coverage:** _____
SERS will notify you of the cancellation date. A requested date may not be accepted if this form is received after the date requested. If left blank, SERS will determine the cancellation date.

**Reason for Cancellation**: _____

**Return completed forms by:**
**Mail:** SERS, 300 E. Broad St., Suite 100, Columbus, Ohio 43215-3746
**Fax:** 614-340-1820