



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 want to keep or cancel your coverage:

DENTAL COVERAGE

- Keep
- Cancel
- Not applicable

VISION COVERAGE

- Keep
- Cancel
- Not applicable

I am waiving SERS health care coverage because:

- I have coverage through my spouse's employer
- I have coverage through my employer
- I have coverage through Medicaid
- I have other coverage that is none of the above

Benefit Recipient Name: _____

Social Security Number: _____

Signature of Recipient: _____ **Date:** _____

Spouse Signature: _____ **Date:** _____
(required if enrolled in health care coverage)

Requested cancellation date of SERS health care coverage: _____

Return by mail to the address at the top of this form or fax to 614-340-1820.