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 health care coverage under another plan. Satisfactory proof of involuntary termination is required.

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	**VISION COVERAGE**
☐ Keep	☐ Keep
☐ Cancel	☐ Cancel
☐ Not applicable	☐ 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,
fax to 614-340-1820, or scan and email to healthcare@ohsers.org.