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

WAIVER AND CANCELLATION OF HEALTHCARE 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' healthcare 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 healthcare enrollment application:
    - Within 90 days of becoming eligible for Medicare, or
    - Within 31 days of the involuntary cancellation of healthcare coverage under another plan. Satisfactory proof of involuntary cancellation 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 healthcare 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 healthcare coverage)

Requested cancellation date of SERS healthcare 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.