

Section B — Waiving medical and/or prescription drug coverage

Complete this section to waive medical and/or prescription drug coverage for yourself and/or your dependents. Please note that if you, the benefit recipient, terminate coverage, then all dependents of the benefit recipient will automatically be waived as well. Dependent only coverage is subject to certain restrictions, please contact OP&F for further information.

Full Name	Social Security Number	Relationship	Date of birth	Waive medical and/or prescription drugs
		SELF		<input type="checkbox"/> Waive medical <input type="checkbox"/> Waive prescription
				<input type="checkbox"/> Waive medical <input type="checkbox"/> Waive prescription
				<input type="checkbox"/> Waive medical <input type="checkbox"/> Waive prescription
				<input type="checkbox"/> Waive medical <input type="checkbox"/> Waive prescription
				<input type="checkbox"/> Waive medical <input type="checkbox"/> Waive prescription
				<input type="checkbox"/> Waive medical <input type="checkbox"/> Waive prescription

Section C — Reason for waiving

Indicate your reason for waiving medical and/or prescription drug coverage for yourself or your dependents listed in Section B.

- Full time student status
- Other insurance (effective date: _____)
Please attach documentation showing proof of new coverage effective date.
- Medicare Part D (effective date: _____)
- Divorce
- Other: _____

Section D — Signature and acknowledgement

By my signature, I authorize OP&F to waive my dependents' coverage or my coverage (if applicable) as indicated in the foregoing sections of this form. I have read the enrollment guidelines listed on this form and understand that I will have very limited opportunities to re-enroll my dependents (or myself) in these plans. I further understand and acknowledge that OP&F will not reinstate this coverage retroactively if I later re-enroll.

Member's Signature ▶	Date of Signature
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