Ohio Police & Fire Pension Fund
140 East Town Street
Columbus, OH 43215
Phone: 1-888-864-8363
Fax: (614) 628–1777
www.op–f.org

TERMINATION OF HEALTH CARE STIPEND

To terminate eligibility for the Ohio Police & Fire Pension Fund (OP&F) health care stipend, the benefit recipient should submit this form to OP&F. Eligibility will end the last day of the month if the form is received prior to the 15th of that month. If the form is received after the 15th of the month, eligibility will end on the last day of the following month.

By terminating eligibility, please remember you may only become eligible again if you experience one of the qualifying life events listed below. Please contact OP&F within 60 days of the qualifying event to request eligibility forms and information.

Qualifying life events are:

- The involuntary loss of group health care coverage;
- A change in family status (i.e. birth, adoption, marriage, divorce);
- At the time of Medicare eligibility; or
- Proof of eligibility in CHIP/Children's Medicaid Program.

Section A: Member information

Name: First, MI, Last, suffix (Jr. III, etc.)

❑ Male ❑ Police
❑ Female ❑ Fire

Social Security Number

Street Address / Post office box

Home telephone

Date of birth

City, State, ZIP code

Alternate telephone

Medicare number (if applicable)

Email

Marital status ❑ Single ❑ Married ❑ Divorced ❑ Married, but previously divorced

If married, spouse's name (first, middle initial, last)

Marriage date(s)

Divorce date(s)

Section B: Reason for terminating eligibility

Indicate your reason for terminating eligibility for the OP&F health care stipend for yourself (person named in Section A) and/or your dependents (listed in Section C):

❑ Health care insurance is available from another source, such as from an employer, spouse's employer, etc. (effective date of coverage: _____)

❑ Dependent child(ren) are no longer eligible.

❑ Medicare Part D (effective date:_____). Please attach documentation showing proof of effective date.

❑ Divorce. Please attach copy of divorce decree.

❑ Other:_____

Section C: Terminating OP&F health care eligibility

Complete this section to terminate health care stipend eligibility for yourself and your dependents. If you, the benefit recipient, terminate eligibility, then all dependents of the benefit recipient will automatically become ineligible as well.

Dependent's name	Social Security number	Date of birth	Gender	Relationship
1			❑ Male ❑ Female	**SELF**
2			❑ Male ❑ Female	❑ Spouse ❑ Child ❑ Other:_____
3			❑ Male ❑ Female	❑ Spouse ❑ Child ❑ Other:_____
4			❑ Male ❑ Female	❑ Spouse ❑ Child ❑ Other:_____
5			❑ Male ❑ Female	❑ Spouse ❑ Child ❑ Other:_____
6			❑ Male ❑ Female	❑ Spouse ❑ Child ❑ Other:_____

Section D: Member signature and acknowledgement

I, the member described in Section A of this *Termination of Health Care Stipend* form, certify that all statements made herein and documentation provided are true and correct.

Member's Signature: ▶	Date of signature:

Section E: Notary public requirement

The notary public in good standing must sign in the space provided in this section and affix their seal.

State of _____, County of _____, ss:

The foregoing *OP&F Termination of Health Care Stipend* was acknowledged before me by the person named in the foregoing Section A, this _____ day of _____ , 20_____.

Affix Seal here	Notary's signature: ▶
	Print name:
	My commission expires: