UnitedHealthcare
9200 Worthington Road
Westerville, OH 43082
Phone: (888) 832-0964
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WAIVER OF HEALTH CARE AND/OR PRESCRIPTION DRUG COVERAGE

To waive health care and/or prescription drug coverage, the benefit recipient should submit this form to UnitedHealthcare Insurance Company (UnitedHealthcare). Terminations will take effect the last day of the month if written requests are received prior to the 15th of that month.If written requests are received after the 15th of the month, coverage will terminate on the last day of the following month (with certain exceptions).

By waiving coverage at this time, please remember you may only re-enroll if you meet one of the qualifying events listed below. Please contact UnitedHealthcare within 60 days of the qualifying event to request a *Health Care Enrollment Form.*

- Three years after the benefit recipient's OP&F retirement, or commencement of benefits.
- With proof of change in family status (i.e. marriage, death, divorce);
- With proof of involuntary loss of group coverage; (i.e. Medicaid, COBRA)
- At the time of Medicare eligibility; or
- Proof of eligibility in CHIP/Children's Medicaid Program.

UnitedHealthcare will not reinstate coverage retroactively if coverage is waived and later reinstated.

Section A — Member Information

Name: First, MI, Last, Suffix (Jr., III, etc.)	☐ Police Officer ☐ Fire Fighter	Social Security Number
Street / P.O. Box		Date of Birth
City, State, ZIP Code	County	
Home telephone	Alternate telephone	E–mail address
Marital Status (do not mark single if you are divorced) ☐ Single ☐ Married ☐ Widowed ☐ Divorced		Marriage Date / Divorce Date

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Section B — Waiving OP&F-sponsored health care coverage

Complete this section to waive health care 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 UnitedHealthcare for further information. Terminating voluntary dental and vision plans are only permitted during the Annual Change Period, unless there is a valid change in family status such as a death or divorce. Please provide documentation of these events if there is to be a termination of this voluntary coverage.

Full Name	Social Security Number	Gender	Relationship	Date of birth	Waive medical and/or prescription drugs
		☐ Male ☐ Female	SELF		☐ Waive AARP Medicare Supplement Insurance ☐ Waive UHC health care ☐ Waive prescription
		☐ Male ☐ Female			☐ Waive AARP Medicare Supplement Insurance ☐ Waive UHC health care ☐ Waive prescription
		☐ Male ☐ Female			☐ Waive AARP Medicare Supplement Insurance ☐ Waive UHC health care ☐ Waive prescription
		☐ Male ☐ Female			☐ Waive AARP Medicare Supplement Insurance ☐ Waive UHC health care ☐ Waive prescription
		☐ Male ☐ Female			☐ Waive AARP Medicare Supplement Insurance ☐ Waive UHC health care ☐ Waive prescription
		☐ Male ☐ Female			☐ Waive AARP Medicare Supplement Insurance ☐ Waive UHC health care ☐ Waive prescription

Section C — Reason for waiving

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

- ☐ Other insurance (effective date: ______________________)
  Please attach documentation showing proof of new coverage effective date.
- ☐ Dependent Child(ren) 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 D — Signature and acknowledgement

By my signature, I authorize UnitedHealthcare 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 UnitedHealthcare will not reinstate this coverage retroactively if I later re-enroll.

Member's Signature	Date of Signature
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