

**OFFICE OF PENSIONS
PENSIONER HEALTH BENEFIT TERMINATION FORM**

Name: _____

SS# or Empl ID: _____

Code: _____

Circle Company: **Blue Cross Blue Shield of DE** or **Aetna**

I wish to cancel my health insurance effective _____ **Date**.

Signature

Date

Phone Number

In most cases, future enrollment opportunities in the plans are restricted to an annual reopening.