

**OFFICE OF PENSIONS
SPOUSAL/DEPENDENT HEALTH BENEFIT TERMINATION FORM**

Name: _____

SS# or Empl. ID: _____

I wish to cancel health insurance for my spouse/dependent(s) listed below:

Spouse/Dependent's Name and SS#

effective _____ **(date) from the Delaware Public Employees'**
Retirement System health plan administered by:

Circle company: **Blue Cross Blue Shield of DE (or) Aetna**

Pensioner's Signature

Date

Phone Number

By signing this form I understand that I can only reenroll an eligible spouse/dependent during the annual benefit reopening period or within 30 days of qualifying event.