

**OFFICE OF PENSIONS
HEALTH BENEFIT TERMINATION FORM
For Spouse/Civil Union Spouse/Dependent/Civil Union Dependent**

Name: _____

SS# or Employee ID: _____

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

Spouse/Civil Union Spouse/Dependent's/Civil Union 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 re-enroll an eligible spouse/civil union spouse/dependent/civil union dependent during the annual benefit re-opening period or within 30 days of a qualifying event.

Please return this form to the Office of Pensions by mail or by fax to the address or fax number below:

**Office of Pensions
McArdle Building
860 Silver Lake Blvd., Ste 1
Dover, DE 19904-2402
FAX # - 302-739-6129**