



# Termination of Coverage

To terminate dental and/or vision coverage, the benefit recipient should submit this form to the Highway Patrol Retirement System (HPRS). Upon receipt, terminations will be effective at month-end, or the effective date noted in Section 3.

Terminating dental & vision coverage is only permitted during the Annual Open Enrollment Period (November 1-30), unless there is a qualifying event during the calendar year such as one of the following:

- *Change in family status (i.e. marriage, death, divorce)*
- *Birth, adoption or guardianship*
- *Change in job status*

**Documentation for the qualifying event must be submitted to HPRS within 60 days of the event.**

You may only re-enroll if you meet one of the qualifying events listed above, or during the open enrollment period. Please visit [www.ohprs.org](http://www.ohprs.org) (under the Members/Forms tab) and provide HPRS a Dental & Vision Election Form within sixty (60) days of the qualifying event.

HPRS will not reinstate coverage retroactively if coverage is terminated and later reinstated.

## Section 1 – Member Information

Last Name

First Name

Middle Initial

Street Address

City

State

Zip Code

XXX-XX-

SSN

DOB

Home Phone

Email Address

Cell Phone

Marital Status (*Single, Married, Divorced, Widowed*)

Marriage Date (*if applicable*)

Divorce Date (*if applicable*)

## Section 2 – Terminating Coverage

Complete this section to terminate coverage for yourself and/or your dependents. **If the benefit recipient terminates coverage, all dependents will automatically be terminated.**

Full Name	SSN	Relationship	Date of Birth	Coverage to be terminated
	XXX-XX-	SELF		Dental Vision
	XXX-XX-			Dental Vision
	XXX-XX-			Dental Vision
	XXX-XX-			Dental Vision
	XXX-XX-			Dental Vision

### Section 3 – Reason for Termination

Indicate below your reason for terminating coverage for yourself or your dependents listed in Section 2 and date for the change to become effective.

Effective date will be the first day of the month following receipt of this form.

### Section 4 – Signature and Acknowledgement

I have read the enrollment guidelines 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 HPRS will not reinstate this coverage retroactively if I later re-enroll.



Signature

Date