Termination of Health Care Coverage

To terminate medical/prescription, 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 (under the Members/Forms tab) and provide HPRS a Health Care 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- | DOB | Home Phone

SSN

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**		☐ Medical/Prescription ☐ Dental ☐ Vision
	XXX-XX-			☐ Medical/Prescription ☐ Dental ☐ Vision
	XXX-XX-			☐ Medical/Prescription ☐ Dental ☐ Vision
	XXX-XX-			☐ Medical/Prescription ☐ Dental ☐ Vision
	XXX-XX-			☐ Medical/Prescription ☐ 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**

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