RETIREMENT ADMINISTRATION

Notice to Discontinue/Waive City Health Care Coverage

Name: ________________________________ EIN: _________________

_____ I wish to discontinue/waive my rights to health care coverage. I realize that by discontinuing/waiving my rights to coverage with the City's group health care plan I will not be eligible to rejoin/join the City's group health care at any future date unless I can provide proof of continuous coverage from the time of cancellation through time of re-application.

_____ I am not currently enrolled in the City's group health care plan. I understand that if I do not enroll in coverage at this time I will not be eligible to re-join the City's policy at a later date.

_____ I am currently enrolled in City's group health care plan through my spouse, who is a City employee. I understand that I may continue on this policy until he/she terminates employment or retires. I am aware that if City coverage is canceled I will need to enroll in the City's health care plan at this time to be eligible to re-join the City's policy at a later date.

___________________________ ___________________________
Signature Date

___________________________ ___________________________
Witness Date