OFFICE OF PENSIONS
TERMINATION FORM - DENTAL &/OR VISION COVERAGE

(Use this form to Terminate Dental and/or Vision Insurance Coverage for Yourself and/or your Spouse and/or Dependents)

Dental and Vision insurance elections are "Binding Elections."
You may only terminate your dental and/or vision insurance coverage during the annual open enrollment period or due to a qualifying event per the State of Delaware Eligibility and Enrollment Regulations. You may make changes to your coverage within 30 days of a qualifying event with required verification.

Pensioner's Name: _____ SS# or Employee ID: _____

Please mark the coverage below to be terminated:

_____ Delta Dental

_____ EyeMed Vision Care

_____ Dominion Dental Services, Inc.

☐ I wish to terminate my (*check coverage to terminate*) ☐ Dental and/or ☐ Vision insurance offered through the Delaware Public Employees' Retirement System during the annual open enrollment period to become effective July 1, 20_____.

OR

☐ I wish to terminate my (*check coverage to terminate*) ☐ Dental and/or ☐ Vision insurance effective _____ (date) due to a qualifying event. I am including documentation verifying this qualifying event as required.

☐ I wish to terminate the (*check coverage to terminate*) ☐ Dental and/or ☐ Vision insurance for *only* my spouse / dependent(s) listed below* effective _____due to a qualifying event. I am including documentation verifying this qualifying event as required.

***LIST SPOUSE / DEPENDENT(S) BELOW:**

_____
Pensioner's Signature _____

_____ _____
Date

_____ _____
Phone Number

By signing this form, I understand that I can only re-enroll during the annual open enrollment period or within 30 days of a qualifying event by providing verification with the appropriate application form.

Please return this form to the Office of Pensions using one of the following methods:

Mail to:
Office of Pensions
McArdle Building
860 Silver Lake Blvd., Ste 1
Dover, DE 19904-2402

Scan & E-Mail to:
pensionoffice@state.de.us

Fax to:
302-739-6129

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