



Agreement to Discontinue Annuitant Health Care Program

Name: _____

Personnel Number: _____

Phone Number: _____

Email Address: _____

I fully understand and acknowledge that my health care coverage is canceled as of _____(the date must be the first of the month). As of this date, I waive all future rights to State System's Annuitant Health Care Program coverage.

Also, State System is released from any future obligation to provide coverage to me and my dependents under the State System's Annuitant Health Care Program as of the date set forth below.

Signature: _____

Date: _____