PERS Oregon Public Employees Retirement System HEALTH INSURANCE PROGRAM
P.O. Box 40187, Portland, Oregon 97240-0187
(503) 224-7377 or 1-800-768-7377

REQUEST FOR INSURANCE CARRIER DISENROLLMENT / TERMINATION

MEMBER INFORMATION:

Member's Name: _____
Last First Middle

Member's Social Security Number: _____

Please terminate coverage for: ☐ Retiree ☐ Spouse ☐ Dependent(s)

Requested Termination Date: _____

MEDICAL COVERAGE:

☐ PacificSource ☐ Kaiser Permanente ☐ ODS (supplement) ☐ Providence Choice ☐ ODS (PPO) ☐ Providence Extra

DENTAL COVERAGE:

☐ ODS Dental ☐ Kaiser Dental

(If the retiree terminates dental coverage, all dependents enrolled will also have their dental coverage terminated.)

Termination from your insurance carrier will be effective on the first day of the month after PERS Health Insurance Program receives this written request (unless a later date of termination is requested.)

Reason for disenrollment/termination (required): _____

PLEASE SIGN AND DATE PRIOR TO THE REQUESTED TERMINATION EFFECTIVE DATE

Member signature: _____ Date _____

Spouse signature: _____ Date _____

Power of Attorney signature: _____ Date _____

Please enclose a copy of the Power of Attorney of the Power of Attorney is signing for the member.

If you are changing insurance carriers through the PERS Health Insurance Program, please be sure that the requested effective date of this termination is the same as the beginning date for the new insurance carrier you are enrolling with through the PERS Health Insurance Program. Please be aware that if you terminate your PERS medical or dental insurance altogether, you may be ineligible to re-enroll in a PERS-sponsored plan in the future. Refer to your member handbook and benefit guide or call the PERS health insurance program for specific eligibility and re-enrollment information before submitting your request.