PERS HEALTH INSURANCE PROGRAM
Public Employees Retirement System

# PHIP Request for Disenrollment

Per OAR 459-035-0080 (2)(a) disenrollment from your PERS Health Insurance Program (PHIP) health plan will be effective the end of the month in which a signed notification is received by PHIP from the covered person to terminate coverage (unless a later date of disenrollment is requested).

| Your Requested Disenrollment Date: _____ / _____ / _____ | Reason For Disenrollment **(Required)**: | | |
|---|---|---|---|
| **PERS Retiree** Last Name | First | MI | SSN and/or PERS ID |
| **Retiree Select The Coverage You Wish To Disenroll From:** ☐ Medicare ☐ Non-Medicare | | | |
| **Please Terminate Coverage For:** ☐ Retiree ☐ Retiree & Family ☐ Spouse/DDP only ☐ Dependent Child(ren) only | | | |

## List Spouse/DDP And Each Dependent Child To Be Disenrolled

| Last Name | First | MI | Spouse or Dependent | Medicare | Non-Medicare |
|---|---|---|---|---|---|
| | | | | ☐ | ☐ |
| | | | | ☐ | ☐ |

## Select The Coverage You Wish To Disenroll From

| **Medicare Medical Options** | | |
|---|---|---|
| ☐ Kaiser | ☐ Moda Health | ☐ Providence |
| ☐ PacificSource | ☐ UnitedHealthcare® | |

| **Non-Medicare Medical Options** | |
|---|---|
| ☐ Kaiser | ☐ UnitedHealthcare® |

| **Dental Coverage**<br>*(Per OAR 456-035-0070 if the retiree disenrolls from dental, all family members will be disenrolled from dental)* | |
|---|---|
| ☐ Kaiser | ☐ Delta Dental Plan of Oregon |

## Sign and Date Prior To the Requested Disenrollment Effective Date

| Retiree Signature/Power of Attorney Signature<br>X | Today's Date |
|---|---|
| Spouse/DDP Signature<br>X | Today's Date |
| Dependent Child Signature *(if over 18 years old)*<br>X | Today's Date |

*Please attach legal documentation if you are the legal guardian or Power of Attorney.*

**Once disenrollment has occurred, you cannot re-enroll unless you experience a new enrollment opportunity. For eligibility and enrollment information visit pershealth.com.**

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