



Washoe County School District
RETIREE TERMINATION FORM

Last Name	First Name	MI	SSN	Date of Birth
Physical Address	City	State	Zip Code	Phone Number
Mailing Address (if different than Physical)	City	State	Zip Code	Email Address
Termination Effective Date	Type of Retiree ☐ Retired Certified ☐ Retired ESP ☐ Retired Administrator			

Coverage to Terminate

- ☐ Medical/Dental
☐ Vision
☐ Gap
☐ Basic Life
☐ Supplemental Life
☐ All Coverage

Reason for Termination:

☐ Medicare Enrollment ☐ Death of Retiree ☐ Enrolled in other Coverage ☐ Voluntary Termination ☐ Other (please specify) _____

Employee Certification:

By signing below, I hereby declare, certify, and state under penalty of perjury that the information I have provided is true and correct to the best of my knowledge. I further acknowledge and understand that by electing to terminate my Medical, Dental, and/or Life Insurance coverage I am voluntarily discontinuing these benefits in accordance with district policies and plan provisions. I understand that termination of coverage may result in limited or no opportunity to re-enroll unless permitted under applicable qualifying life events or future open enrollment periods in accordance with NRS.

Life Insurance Acknowledgment:

I specifically understand that if I terminate my Life Insurance coverage, I will not be eligible to re-enroll in the district provided Life Insurance policy at a later date.

Retiree Signature _____ Date Signed _____

Benefits Department Use Only		
Date Received: _____	Processed By: _____	Effective Date: _____