Agreement to Cancel Annuitant Health Care Program

Name:
Personnel Number:
Phone Number:
Email Address:

Per my request, please cancel my Pennsylvania's State System of Higher Education Annuitant Health Care Program (AHCP) Medical and Prescription coverage effective _____ (the date must be the first of the month).

By signing and submitting this form, I fully understand and acknowledge the following:

- that my health care and prescription coverage will be canceled effective the date above,
- that I waive all future rights to the State System AHCP coverage, and
- that the State System is released from any and all future obligation to provide coverage to me and my dependents under the State System's AHCP.

Signature: _____

Date Signed: _____