Waiver of Retiree Medical Coverage

Office # _____

Member Name_____

Address_____

Social Security Number_____ Date of Birth_____

This is to acknowledge and certify that I have been informed that I am eligible for Retiree Medical Benefits currently administered by the Cook County Pension Fund under the current eligibility rules of the Cook County Pension Fund.

However, effective with the date of my annuity and upon signing this form, I hereby decline and waive retiree medical coverage for myself and any of the eligible dependent(s) in such benefits. I understand and acknowledge that these benefits include the Fund's Medical and Prescription Drug Plan.

I understand and acknowledge that if I wish to enroll myself and any eligible dependents(s) in the future Retiree Medical Benefits administered by the Cook County Pension Fund at that time, I will be permitted to do so, upon submission to the Fund of proof of the loss of other coverage, within 30 days of such loss, or at the next open enrollment period, whichever is sooner.

I hereby agree to indemnify and make whole the Fund, its heirs and assigns against any and all liability and/or loss arising out of my request to decline and waive coverage for myself and any eligible dependents.

Member's Signature _____ Date_____