Medical RAMP Deferral Form

Name: _____ T#_____

Name(s)	Medical RAMP Deferral	Current Age	Office Use Only
SELF			

I understand that by signing below, I am declining RAMP retiree health insurance coverage for myself and any eligible dependents effective January 1, 2020. I am responsible for paying premiums for coverage through December 31, 2019. I acknowledge that I will have the opportunity to re-enroll with RAMP or Retiree Coverage upon reaching age 62.

Employee Signature _____ Date: _____

Effective Date _____

For Office Use Only: PDADEDN____ PDABCOV____ Web Entry Date:_____