City of Dallas

Waiver of Retiree Benefits

EMPLOYEE ID # _____ **EMPLOYEE PHONE # _____**

I, _____, hereby waive my right to participate in the City of Dallas retiree insurance benefits program. I understand this waiver permanently cancels my City of Dallas retiree benefit coverage(s).

By signing this waiver, I acknowledge that I am no longer eligible to enroll in City of Dallas benefit coverage in the future. I also acknowledge that I lose any Medicare subsidy previously provided to me by the City of Dallas.

I further understand that my health benefits will terminate at the end of the month in which this waiver is received.

Executed this_____ day of _____, 20_____.

By: _____

Signature

Updated 1/2/2020