

HARRIS COUNTY AND HARRIS COUNTY FLOOD CONTROL DISTRICT  
WAIVER OF RETIREE HEALTH & RELATED BENEFITS

Name: \_\_\_\_\_ Social Security # \_\_\_\_\_

As an employee of Harris County or Harris County Flood Control District, I understand that I am entitled to continue my participation in certain Group Health & Related Benefits plans upon my retirement. I hereby decline this coverage for myself and my eligible dependents (if applicable).

I understand that this waiver applies to the medical, dental, vision, and life insurance programs offered to Harris County retirees. I also understand that my decision is **final and irrevocable and I will not be able to begin participation at any time in the future.**

I attest that I have made this decision of my own accord with no pressure or coercion from Harris County or Harris County Flood Control District, or their agents, or the insurance carriers.

Employee's  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed  
Name: \_\_\_\_\_

FOR AUDITORS USE ONLY:

INSURANCE TERMINATION EFFECTIVE DATE: \_\_\_\_\_