Medical Insurance Waiver Form

Dundee Central School District

On behalf of myself and my eligible dependents (if any), I acknowledge that the employer/district has offered me the opportunity to enroll in its medical insurance plan(s) and I hereby waive enrollment in the employer/school district medical insurance plan(s) at this time for the following reason:

- ○ I am covered under another plan as a spouse or dependent
- ○ I have coverage through a plan offered through an Exchange
- ○ I am covered by Medicare, non-group, or a Veterans program
- ○ I am covered under another plan sponsored by a second employer
- ○ Other – Please detail reason -____

If declining to participate in the employer/district medical insurance plan at this time due other health coverage listed above, please provide the following information:

Print Subscriber Name: ____
Carrier Name: ____
Group/Policy Number: ____

Even though you are declining enrollment at this time, you will be able to enroll in the (employer/district Name) medical insurance plan during the plan's future open enrollment periods if you remain eligible for insurance through the employer/district. In addition, you may be able to enroll at other times during the year if you experience a qualifying change in family status such as the birth or adoption of a child, a marriage or divorce, or the loss of other coverage.

Print Employee Name:

Employee Signature:____Date:______________________

I affirm that the assertions in this form are true and complete to the best of my knowledge.

Employer Signature:____Date:________________

Please complete and sign this form and return to the Business Office.