INSURANCE WAIVER

To: New Hope-Solebury School District/Business Office

From: _____
(PRINT NAME)

Effective _____, I elect to waive the following plan coverage(s):
(Please initial)

Health/Prescription Insurance Plan _____

Dental Insurance Plan _____

Vision Insurance Plan _____

I understand I need to provide copies of my insurance cards or proof that I have active Health/Prescription coverage and I affirm, under penalty of perjury, that the document(s) are true and correct.

I also understand once I cancel the insurance coverage I am not eligible to re-enroll until the next Open Enrollment Period*.

_____
Signature Date

** Unless there is a **Qualifying Life Event** such as marriage, birth or adoption of a child, divorce, or spouse loss of job. Employee must submit evidence in writing within 30 days from date of occurrence to the Business Office.*

Open Enrollment Period occurs annually prior to July-June Plan Year

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Completed form received in payroll on: _____

Information updated in all necessary systems by _____ on _____.
Printed name Date