LINDEN BOARD OF EDUCATION

HEALTH COVERAGE WAIVER

Employee Name _____ Date of Hire _____

I acknowledge that I have been given the opportunity to enroll myself and eligible dependents in Linden Board of Education's group health insurance plan.

I DECLINE MEDICAL ☐ DENTAL ☐ ENROLLMENT AT THIS TIME BECAUSE:

☐ I am covered by my spouse's/domestic partner's coverage

Insurance Name/ID _____

☐ Other (please explain) _____

_____

_____

I understand that by waiving coverage I will not be able to enroll in this health plan until the next open enrollment, unless there is a qualified change in status. Examples include; if you are covered under another plan but that coverage is lost, or if you gain a new dependent through birth, adoption, or marriage. However, you must request to enroll in your plan within 30 days of the qualified change in status. If you miss the 30-day deadline, you must wait until open enrollment.

Employee Signature _____ Date _____