

**Washington Central Supervisory Union**

**WAIVER OF COVERAGE**

Employee's Name: \_\_\_\_\_

**Please check the appropriate answers.**

I choose to decline enrolling myself and/or my eligible dependent(s) in the group insurance plan(s) indicated below. (Please indicate your waiver of coverage by checking all applicable categories and selected family members.)

- Group Dental Plan
- Exclude myself
- Exclude my spouse
- Exclude my child(ren)

Reasons For Declining Coverage:

- Covered by spouse's plan
- Covered by other insurance
- Covered by H.M.O.
- Other (Explain)

I acknowledge that my employer has explained the coverage(s) available. I have been given the opportunity to enroll in my employer's group medical plan for the coverage(s) and have elected not to enroll myself and/or my dependents, if any. I understand that I will not be able to enroll in the Plan until the next open enrollment period.

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

**SIGN ONLY IF COVERAGE IS BEING WAIVED**