ALCOTT SCHOOL

Health Benefits Waiver of Coverage

Employee Name: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Date of Employment: _____

Date of Birth: _____

I am employed by and working at least 30 hours per week for the group shown above. I was given the opportunity to enroll in the group health benefits plan(s) offered by my employer and I refuse coverage.

Reason for Refusal (please check all appropriate boxes)

☐ I have other coverage from:

- ☐ My spouse's employer
- ☐ Medicare
- ☐ Medicaid
- ☐ Veteran's Administration

☐ I have refused coverage. By refusing group health benefits, I acknowledge that I and/or my dependent(s) may have to wait until the plan's next anniversary date to be enrolled for group coverage.

I certify that all information provided in this form is true and complete.

_____

Signature of Employee Date

_____

Signature of Benefits Administator Date