FLOYD COUNTY PUBLIC SCHOOLS

Waiver of Group Health/Dental Benefits & Notice of Special Enrollment Rights

Please complete the following:

Employee Name _____ **Employee Number** _____

I acknowledge that I am declining the following employer-provided group health insurance and/or group dental insurance coverage(s) during the initial enrollment period and/or during any subsequent open enrollments:

1) I am waiving group HEALTH/MEDICAL benefit coverage for:

☐ Myself ☐ Spouse ☐ Dependent(s) – Please list names:

_____

I am waiving coverage due to:

☐ My preference not to have coverage

☐ Coverage under my spouse's plan – name of carrier: _____

☐ Other coverage – name of carrier: _____

This other coverage is: ☐ Individual ☐ COBRA ☐ Medicare ☐ TRICARE (formerly CHAMPUS) ☐ Medicaid ☐ Employer-Sponsored Group Plan

2) I am waiving group DENTAL benefit coverage for:

☐ Myself ☐ Spouse ☐ Dependent(s) – Please list names:

_____

I am waiving coverage due to:

☐ My preference not to have coverage

☐ Coverage under my spouse's plan – name of carrier: _____

☐ Other coverage – name of carrier: _____

This other coverage is: ☐ Individual ☐ COBRA ☐ Medicare ☐ TRICARE (formerly CHAMPUS) ☐ Medicaid ☐ Employer-Sponsored Group Plan

3) I am waiving group VISION benefit coverage for:

☐ Myself ☐ Spouse ☐ Dependent(s) – Please list names:

_____

I am waiving coverage due to:

☐ My preference not to have coverage

☐ Coverage under my spouse's plan – name of carrier: _____

☐ Other coverage – name of carrier: _____

Special Enrollment Notice and Certification – *Please review and sign below if you wish to waive coverage.*

By signing below, I certify that I have been given an opportunity to apply for coverage for myself and my eligible dependents, if any. I am declining enrollment as indicated above. I understand that I am declining enrollment for myself or my eligible dependents (including my spouse) because of other health insurance or group health plan coverage, I may be able to enroll myself and my eligible dependents in this plan if I lose, or my eligible dependents lose, eligibility for that other coverage (or if the employer stops contributing towards my or my eligible dependents' other coverage.)

I understand that I must request enrollment no more than 30 days after the date the other health plan coverage ends (or after the employer stops contributing toward the other coverage). If I do not do so, I will not be able to enroll until my employer's next annual open enrollment period. In addition, I understand that if I have a newly eligible dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my eligible dependent(s). However, I must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

I understand that in order to request special enrollment or obtain more information, I should contact my group administrator.

Signature of Employee Date of Signature

Return this form to Floyd County Public Schools

(Revised 06/26/2018)