According to the individual collective bargaining agreements, only qualified employees are eligible.

Baldwin-Whitehall School District
District Administration
4900 Curry Road
Pittsburgh, PA 15236

Health Insurance Benefit Waiver/Opt-Out Request

Name _____ **Building** _____

Position _____

I hereby notify the Baldwin-Whitehall School District that I wish to waive my participation in the District's group insurance plans, as follows, in lieu of a supplemental payroll payment. Such payment will be made in accordance with the Compensation/Benefit Policy.

*I waive my coverage in the following plans:

(Please check one)

- ☐ **All Coverage**
- ☐ **Medical Coverage only**
- ☐ **Dental Coverage only**
- ☐ **Vision Coverage only**

(Please check one)

- ☐ **Individual**
- ☐ **Parent/Child**
- ☐ **Parent/Children**
- ☐ **Husband/Wife**
- ☐ **Family**

This waiver will remain in effect for the entire **2019/2020** school year. I understand that during this period, I may not rejoin the plan for any reason except for the following non-medical instances as follows:

1. death, layoff, discharge or other loss of benefits by the person whom I am relying for benefits or
2. divorce or separation is shown to cause loss of benefits or
3. during any open enrollment period and
4. the amount of your payment will be pro-rated upon re-enrollment in the plan.

At the end of this waiver period, you may either rejoin the plan or waive your coverage for the next school year.

***A letter/document (not insurance card) from your spouse's/parent's employer must be included with this form stating that you are enrolled in Medical, Dental, Vision (that applies) plus the following type of coverage—Individual; Parent/Child; Parent/Children; Husband/Wife; or Family.**

Signature _____ **Date** _____

Please return this form to Georgann Helman, Administration Office, by June 7, 2019.

For Business/Human Resources Office Use Only