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

Baldwin-Whitehall School District
Health Insurance Benefit Waiver/Opt Out Request

Name_____ **Building**_____

Social Security Number_____-____-_____ **Job Assignment** _____

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) ☐ **Individual** ☐ **Parent/Child** ☐ **Parent/Children**
☐ **Husband/Wife or** ☐ **Family**

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

This waiver will remain in effect for the entire **2018/2019** 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 prorated portion of savings must be returned upon re-enrollment in the plan.

Signature _____ **Date** _____

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

New waivers will be required each year. New letters from your spouse's employer showing what coverage you have (husband/wife or family) is also required.

Please return to Georgann Helman, Administration Office, by June 8, 2018.

Total Waiver Due:_____