Wayne Board of Education
Waiver of Health Coverage

Name (please print):_____

Social Security Number (Last 4 Digits):_____

School/Location:_____ Effective Date: _____

I understand that the Wayne Board of Education offers incentive to employees who waive health coverage under the provisions of their employee agreements and/or Chapter2, P.L. 2010, whichever is less. I wish to waive all of my insurance coverage and that of all my eligible dependents in exchange for the incentive contained in the employee agreement which applies to me, understanding that a condition of being eligible for this waiver is that I certify that I and all my eligible dependents receive health care benefits as a dependent of my spouse or parent. I hereby certify that the source of that other coverage is:

Name of Insured:_____ Relation To Insured:_____

Name & Address of Insured's Employer:_____

Name of Health Plan:_____

Plan/Group #_____

Note: Proof of coverage is required and a copy of your ID card must be provided to process this waiver.

By signing and returning this form, I understand that I am waiving my rights to all health coverage offered by the Wayne Board of Education until next open enrollment period, currently scheduled for November of this year. If my family circumstances change (change in family circumstance would be if an employee ceases to be covered through his/her spouse or parent for any reason). I will only be able to rejoin the medical plan offered by the Wayne Board of Education if I apply in writing for reinstatement. I understand that any reinstatement accomplished through the open enrollment, November of this calendar year, would be effective January of the next year.

Sign Here_____