ALCOTT SCHOOL

HEALTH BENEFITS WAIVER OF COVERAGE

Employee Name: _____

Marital Status: Single ___ Married ___ Divorced ___ Widowed___

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.

Reason for Refusal (please check all appropriate boxes)

☐ I have other coverage from:
- ☐ My spouse/domestic partner
- ☐ My parents (under age 26)
- ☐ Medicare
- ☐ Medicaid
- ☐ Veteran's Administration
- ☐ Other _____

☐ I have refused coverage. By refusing 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 on this form is correct.

_____ _____
Signature of Employee Date

_____ _____
Signature of Benefits Administrator Date

www.alcottschool.org

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