

INSURANCE WAIVER VERIFICATION

NAME _____ SOCIAL SECURITY # _____

STREET ADDRESS _____

CITY/STATE/ZIP _____

POSITION _____

I HEREBY AGREE TO WAIVE MY RIGHT OF HAVING MY EMPLOYER PROVIDE

HEALTH INSURANCE _____
DENTAL INSURANCE _____

I HEREBY ATTEST TO THE FACT THAT I WOULD HAVE BEEN ENTITLED TO INSURANCE COVERAGE FOR _____ SINGLE PLAN _____ TWO PERSON PLAN _____ FAMILY PLAN
 (If two person plan, or family plan, list dependents and social security numbers below)

Name	_____	SS#	_____	D/O/B	_____
	_____		_____	D/O/B	_____
	_____		_____	D/O/B	_____
	_____		_____	D/O/B	_____

If your dependent child is over 19, is your child a full time student? _____ If so, where _____

I ALSO ATTEST THAT ACCORDING TO MY UNION CONTRACT I WOULD HAVE BEEN ENTITLED TO

HEALTH INS. PLAN _____
 DELTA DENTAL PLAN _____

ACCORDING TO MY UNION CONTRACT I AM ENTITLED TO A "CASH BACK" INCENTIVE. THIS INCENTIVE IS TO BE ADDED TO MY REGULAR PAYCHECKS FOR THE _____ PAYPERIODS THAT I AM ENTITLED TO.

BY WAIVING HEALTH/DENTAL INSURANCE, I MUST PROVIDE PROOF THAT I HAVE OTHER MEDICAL/DENTAL INSURANCE COVERAGE.

MEDICAL INSURANCE COMPANY _____
 PLAN NUMBER _____
 EMPLOYER PROVIDING COVERAGE _____

DENTAL INSURANCE COMPANY _____
 PLAN NUMBER _____
 EMPLOYER PROVIDING COVERAGE _____

 SIGNATURE

 DATE

Office Use

HEALTH INSURANCE COST	
DENTAL INSURANCE COST	
TOTAL SCHOOL DISTRICT COST	
EMPLOYER COST	
# PAY PERIODS	
PAY PERIOD AMOUNT	