FLASHP
Finger Lakes Area School Health Plan

Medical Insurance Waiver Form

WAYLAND-COHOCTON CENTRAL SCHOOL DISTRICT

On behalf of myself and my eligible dependents (if any), I acknowledge that the employer/district has offered me the opportunity to enroll in its medical insurance plan(s) and I hereby waive enrollment in the employer/school district medical insurance plan(s) at this time for the following reason:

- ○ I am covered under another employer-sponsored group health plan as a spouse or dependent
  Please indicate if this is a High Deductible Health Plan _____Yes _____No
- ○ I have individual coverage procured through a broker or a public health insurance Exchange
- ○ I am covered by a government program such as Medicare, Medicaid, TRICARE, etc.
- ○ I am covered under another plan sponsored by a second employer
- ○ Other – Please detail reason _____

If declining to participate in the employer/district medical insurance plan at this time due to other health coverage listed above, please provide the following information:

Print Subscriber Name: _____
Carrier Name: _____
Group/Policy Number: _____

Even though you are declining enrollment at this time, you will be able to enroll in the Wayland-Cohocton School District medical insurance plan during the plan's future open enrollment periods if you remain eligible for insurance through the Wayland-Cohocton School District In addition, you may be able to enroll at other times during the year if you experience a special enrollment event or other qualifying change in status, such as the birth or adoption of a child, a marriage or divorce, or the loss of other coverage.

Print Employee Name: _____

Employee Signature:_____Date:_____

I affirm that the assertions in this form are true and complete to the best of my knowledge.

Signature:_____Date:_____

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