BLAINE SCHOOL DISTRICT NO. 503
MEDICAL WAIVER FORM

EMPLOYEE: _____ **SSN:** _____

I have been given the opportunity to enroll myself and my eligible dependents in the medical plans sponsored by my employer.

I understand that if I request health care coverage under this plan at a later date for myself or my dependents, coverage will be denied except:

1. during the annual open enrollment period specified in my employer's Group Medical coverage contract; or
2. as specified in the Health Insurance Portability and Accountability Act of 1996:
   * by special enrollment within 30 days after involuntarily loss of coverage; or
   * by special enrollment for both myself and my dependent(s) within 60 days after a dependent is added to my family through marriage, birth, adoption or placement by the courts.

EMPLOYEE WAIVER

I chose to waive coverage for myself for the reason(s) indicated below:

- ☐ Covered by another employer-sponsored Group Medical Plan.
  Group Medical Plan: _____
- ☐ Receive medical benefits from the U.S. Government through active or retired military medical coverage.
- ☐ Covered by Medicare.
- ☐ Other (please specify) _____

DEPENDENT WAIVER

- ☐ I have no dependents.

I chose to waive coverage for my

- ☐ Spouse
- ☐ Child(ren)

_____ _____

Employee Signature **Date**

Payroll must receive your completed form by May 10, 2004 in order to cancel your medical coverage effective 05/31/04 and have no further medical premiums deducted from your paycheck (if applicable).