NORTH BABYLON UNION FREE SCHOOL DISTRICT
North Babylon, New York

DECLINATION OF HEALTH AND/OR DENTAL/VISION BENEFITS

(Please Print)

(Last Name) (First Name) (Middle Initial) (Building)

(Address) (Social Security No.)

(Phone #) (Cell Phone# - Optional) (Date of Employment)

I hereby decline enrollment in the following:

☐ **HEALTH BENEFIT**

☐ **DENTAL/VISION BENEFIT**

This is to be effective the first day of _____ , 20 ____
(Month)

In consideration of this, the sum of $550 for health benefits and $150 for dental/vision benefits will be made payable to me by the District in two payments. These reimbursements will be paid at the end of June and December of each year. (Less than a full year of eligibility will be pro-rated). **I have declined health insurance so attached is a copy of my current health benefit card**.

This declination shall remain in full force and effect while employed by the North Babylon Union Free School District for the calendar year _____.

I may subject myself and/or my eligible dependents to certain applicable waiting periods if I decide to enroll at a later date.

_____ _____
(Signature) (Date)