



PALMYRA BOARD OF EDUCATION

PALMYRA, N.J. 08065

Brian J. McBride
Superintendent of Schools

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William R. Blatchley
*Business Administrator/
Board Secretary*

INSURANCE COVERAGE WAIVER/REINSTATEMENT

1. Name: _____ SS# _____
Print

☐ **Waiver of Coverage**

I have agreed to waive coverage for medical and prescription drug coverage with the Palmyra Public School District's Health Benefits Program which I am entitled because I am covered under other health coverage. **(Note: You must submit proof of the other health coverage along with this form.)**

☐ **Reinstatement of Coverage**

I previously waived medical and prescription coverage because I had other health coverage. As of _____, I am no longer covered by the other health plan, and request to be
Date
enrolled in the Palmyra Public School District's health benefits, and have provided proof of loss of other coverage.

Employee Signature _____ Date _____