Waiver of Group Benefits and Notice of Special Enrollment Rights

Lake Shore Public Schools

Employee Name: _____ **Employee ID:_____**

For the 2020 plan year effective **January 1, 2020**, I am waiving coverage for (please check):

☐ Health ☐ Dental ☐ Vision

For:

☐ Myself ☐ My Spouse ☐ Dependent (s)- Please list names

_____ _____

_____ _____

I am waiving coverage due to:

☐ Coverage under my spouse's plan - name of carrier:_____

☐ Other coverage - name of carrier: _____

This other coverage is: ___Individual ___ COBRA ___Medicare

___ Medicaid ___ Employer-Sponsored Group Plan

Special Enrollment Notice and Certification - Please review and sign below if you wish to waive coverage

By signing below, I certify that I have been given an opportunity to apply for coverage for myself and my eligible dependents, if any. I am declining enrollment as indicated above. I understand that I am declining enrollment for myself or my eligible dependents (including my spouse) because of other health insurance coverage or group health plan coverage. I may be able to enroll myself and my eligible dependents in this plan if I lose, or my eligible dependents lose, eligibility for that other coverage.

I understand that I must request enrollment no more than 30 days after the date the other health plan coverage ends. If I do not do so, I will not be able to enroll until my employer's next annual open enrollment period.

In addition, I understand that if I have a newly eligble dependent as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and eligible dependent(s). However, I must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

I understand that in order ro request special enrollment or to obtain more information, I should contact Misty Blaesing, Payroll Supervisor.

_____ _____

Employee Signature Date

Return completed form to Misty Blaesing at the Admin Center.