Loyalsock Township School District

Waiver of Group Health Insurance

Personal Information

Employee Name: Last, First, MI	Social Security Number
Home Mailing Address	
City, State, Zip	Date of Birth

Waiver of Coverage

I hereby elect to waive health plan coverage offered to me as a Loyalsock Township School District employee for the current benefit plan year, and for all subsequent annual coverage periods, due to the fact that I have health insurance coverage through another plan.

I understand that by signing this Waiver, I am waiving coverage, not only for myself, but for my Spouse and Dependents, if applicable.

I understand that, by waiving my insurance coverage, I am entitled to an annual payment from Loyalsock Township School District based on the current contractual agreement in place, in lieu of accepting the health benefit. There will be two equal payments, paid on the last pay in December and the last pay in June of each plan year. I understand that if I have a change in eligibility and need to enroll in the District health plan, my payment will be prorated.

I understand that this is a binding election until revoked during a future enrollment period or by the occurrence of a qualified change in my family status as defined by the Regulations issued by the Internal Revenue Service. Notwithstanding the foregoing, however, I understand that if the alternate health insurance coverage I am currently receiving should cease as a result of loss of eligibility or termination of employer contributions, I must notify the Loyalsock Township School District benefits office of the termination of the alternate health insurance coverage and request enrollment in a Loyalsock Township School District Plan within 31 days of the termination of coverage in order to become covered under the District's Plan(s). I understand that if I do not request enrollment within 31 days of termination of coverage, I will not be eligible to enroll in any District health plan until the following annual enrollment which shall be effective the first day of the following plan year.

Authorization

Effective date of Waiver _____

Employee Signature _____ Date _____

If you have any questions, contact the District Service Center at 570-326-6508.
Return this form to the District Service Center, 1605 Four Mile Drive, Williamsport, PA 17701.