WAIVER OF INSURANCE BENEFITS – ASHFORD BOARD OF EDUCATION

This form must be filed with the Office of the Superintendent of Schools on or before September 1st each year in order to be eligible to receive waiver compensation as defined by current collective bargaining agreements.

CHECK ONE: New Employee (Add) ☐ Existing Employee (Change) ☐

NAME OF EMPLOYER: Ashford Board of Education POLICY NUMBER: 089233
EMPLOYER ADDRESS: 440 Westford Road, Ashford, CT 06278

Name of Employee: ______________________________
Employee Occupation: ______________________________
Home Address ______________________________
Employee Social Security Number: __________________ Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Civil Union
Contact Phone: Work ______________ Home: ______________
Where would you prefer to be contacted during the day? ( ) Home ( ) Work

Are you actively at work, full-time? (30 or more hours per week) YES ☐ NO ☐ Date of Hire: ____________

Do you have other insurance coverage elsewhere? YES ☐ NO ☐
IF SO, PLEASE PROVIDE THE FOLLOWING:
Insured's Name: ______________________________
Employer: ______________________________
Name of Insurance Provider: ______________________________
Policy/ Identification Number ______________________________

List Eligible Dependents Covered Under Above Noted Insurance					
Name	DOB	Sex (M/F)	Relationship to Employee	Full-Time Student? If Yes, Where?	Is the dependent employed? If yes, list name of employer

COMPLETE BELOW:

( ) I **DECLINE** ENROLLMENT IN THE HEALTH/DENTAL INSURANCE PLANS OFFERED TO ME BY THE ASHFORD BOARD OF EDUCATION DUE TO THE EXISTENCE OF OTHER GROUP HEALTH COVERAGE FOR:
MYSELF ( ) SPOUSE ( ) DEPENDENT CHILDREN ( )

( ) I **DECLINE** ENROLLMENT IN THE HEALTH/DENTAL INSURANCE PLANS OFFERED TO ME BY THE ASHFORD BOARD OF EDUCATION AND REQUEST WAIVER COMPENSATION FOR:
MYSELF ( ) SPOUSE ( ) DEPENDENT CHILDREN ( )

ATTESTATION:

I hereby represent and agree that the information above and statements in this request are full, complete and true, to the best of my knowledge and belief, and understand that the said answers and statements form the basis upon which healthcare waiver compensation will be paid. I understand that any omission, misrepresentation, or misstatements on this form may result in denial of eligibility for healthcare waiver compensation and may result in reimbursement to the Ashford Board of Education for any portion of healthcare waiver paid.

______________________________ ____________________

Employee Signature **Date**

CC; Business Office
Personnel File