NEW LONDON PUBLIC SCHOOLS
BUSINESS OFFICE

INSURANCE WAIVER FORM FY 2023 - 2024

EMPLOYEE NAME: _____
Print clearly

SCHOOL: _____

AFFILIATION: ☐ **CUSTODIAN** ☐ **NLAEA** ☐ **NLEA** ☐ **PSA** ☐ **UNAFFILIATED** ☐ **AFT**

I acknowledge I have been offered the opportunity to enroll myself and eligible family members in insurance coverage through the New London Public Schools and voluntarily elect to waive such coverage.

To exercise this waiver option, this form must be submitted to the **Business Office** not later than June 20 in any year covered by such waiver to be effective the following September 1.

I hereby elect to waive:

☐ **Medical/Rx Insurance**

☐ **Dental Insurance**

List of Dependents:

Spouse Name:_____

Dependent Children:

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

If you are declining enrollment for yourself or your dependent (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

_____ _____
Employee signature Date