HEALTH INSURANCE WAIVER FORM
2024-2025

TRUMBULL BOARD OF EDUCATION
Trumbull Public Schools

Type of Waiver	
Single	◯
2 Person	◯
Family	◯

THIS FORM IS TO BE COMPLTETED IF YOU ARE **DECLINING BOTH THE MEDICAL AND DENTAL COVERAGE** OFFERED BY THE TRUMBULL PUBLIC SCHOOLS FOR THE PLAN YEAR 2024-2025. BASED ON YOUR BARGAINING AGREEMENT/UNION CONTRACT, YOU MAY BE ENTITLED TO A HEALTH INSURANCE WAIVER PAYMENT WHICH WILL BE DISBURSED BASED ON THE DATES OUTLINED IN YOUR UNION CONTRACT. FAILURE TO RETURN THIS SIGNED FORM DURING OPEN ENROLLMENT EACH YEAR WILL DISQUALIFY YOU FROM RECEIVING THE WAIVER PAYMENT FOR THAT YEAR.

YOU MAY ENROLL IN THE VISION COVERAGE AND STILL BE ELIGIBLE FOR THE WAIVER PAYMENT.

Employee Name (Last, First)		EFFECTIVE DATE	7/1/2024
Street Address		EMPL NO.	
City, State & Zip		GROUP	
Phone No. (Home) *		HIRE DATE	
Phone No. (Cell) *		EMAIL	

** Please indicate at least 1 phone number* *optional*

Please complete the section below for yourself and all eligible depependents. If we do not already have a copy of your marriagle license and/or child(ren)'s birth certificates for all dependents listed below, please forward them to the Insurance Department at Long Hill - Attn: Christine Madden

	NAME (Last, First)	DOB
Employee		
Spouse		
Dependent		
Dependent		
Dependent		
Dependent		

Are you covered under any TRUMBULL BOARD of EDUCATION or TOWN OF TRUMBULL health plan through your spouse or parent?

YES ◯ NO ◯

By signing below, I confirm that I am declining both Medical and Dental coverage for the 2024-2025 plan year

EMPLOYEE SIGNATURE: _____ DATE: _____

Please do not complete below - For Insurance Dept. Use only

	Type	Mos.	FTE	Notes
Employee Only				
2 Person				
Family				