



BRISTOL WARREN REGIONAL SCHOOL DISTRICT

235 HIGH STREET, 2nd FLOOR, BRISTOL RI 02809

WWW.BWRSD.ORG (401) 253-4000

BENEFITS WAIVER FORM

Please be aware that you are electing to waive all health and/or dental insurance coverage under the Bristol Warren Regional School District plans. Should you need coverage(s) in the future, it is required that you notify the Human Resources Department in writing within thirty (30) days in advance of your intent to reinstate your benefit(s).

I, _____, understand that I waive any claim(s) incurred during this period of time and until it is deemed appropriate by me to again become a participating member of the health and/or dental insurance coverage provided by the Bristol Warren Regional School District.

Please select coverage(s) to waive:

Health

Dental

EMPLOYEE SIGNATURE: _____ DATE: _____