



For Office Use Only:

COBRA _____

Waiver Form to Decline Medical Coverage PLAN YEAR 2025

Employee Name:	Employee Social Security Number:
Employee Date of Birth:	E# and Campus:

I have been offered coverage under Pflugerville ISD's group medical plan and am declining coverage for the following reason:

- ☐ I am covered by Medicaid/Medicare
- ☐ I am covered by TRS Care
- ☐ I am covered by an individual plan
- ☐ I am covered under another health plan (check one)
Spouse _____ Parent _____ Military _____ Exchange _____
Other (please list coverage) _____
- ☐ I choose not to be covered - I elect to waive coverage in the Pflugerville ISD medical plan. I understand that the medical insurance offered by PfISD is affordable per the Affordable Care Act (ACA) guidelines and if I choose not to take medical coverage through PfISD, and don't have coverage elsewhere (for me and my family members), I may be assessed a penalty/fee by IRS, per the ACA.

Employee Signature: _____

Date: _____