REFUSAL OF GROUP INSURANCE COVERAGE

I, _____, understand that I have been offered the opportunity to enroll into the group health insurance programs offered by the Washoe County School District. This includes all District benefit programs, including the medical, dental, vision, and life insurance programs. I understand the available coverage options that are available to me and to my dependents, and I know that I have every right to enroll in coverage at this time. After careful and deliberate consideration, I hereby freely, and without undue influence or pressure from the District, refuse this opportunity to enroll into the programs for myself and all of my dependents listed below:

Spouse: _____

Child: _____

Child: _____

Child: _____

Child: _____

Child: _____

This refusal applies to the coverage period starting _____ and ending _____ . I understand that I may enroll into these programs only during the District's "Open Enrollment" period and/or if there is a qualifying event.

This refusal applies to the following benefits: Medical, Dental, Vision and Life Insurance.

Name Date

Social Security Number

Please return to Benefits