



Participant Waiver Form

Date: _____

Employee name: _____

Department: _____

Position: _____

I acknowledge I have been offered the opportunity to enroll myself and eligible family members in USD 250 group medical, dental, and vision insurance plan.

I decline to enroll myself or my eligible family members in the group medical insurance plan through **Blue Cross Blue Shield of Kansas**.

I decline to enroll myself or my eligible family members in the group dental insurance plan through **Delta Dental**.

I decline to enroll myself or my eligible family members in the group vision insurance plan through **VSP**.

I have other medical coverage provided by:

Employer Name: _____

Insurance company name: _____

Policy/group number: _____

Signature: _____

Date: _____