

INSURANCE WAIVER VERIFICATION

NAME _____ **SOCIAL SECURITY #** _____
STREET ADDRESS _____
CITY/STATE/ZIP _____
POSITION _____

I HEREBY AGREE TO WAIVE MY RIGHT OF HAVING MY EMPLOYER PROVIDE

HEALTH INSURANCE _____
DENTAL INSURANCE _____

I HEREBY ATTEST TO THE FACT THAT I WOULD HAVE BEEN ENTITLED TO INSURANCE
 COVERAGE FOR _____ SINGLE PLAN _____ TWO PERSON PLAN _____ FAMILY PLAN
 (If two person plan, or family plan, list dependents and social security numbers below)

Name _____	SS# _____	D/O/B _____
_____	_____	D/O/B _____
_____	_____	D/O/B _____
_____	_____	D/O/B _____

I ALSO ATTEST THAT ACCORDING TO MY UNION CONTRACT I WOULD HAVE BEEN ENTITLED TO

HEALTH PLAN _____
DENTAL PLAN _____

ACCORDING TO MY UNION CONTRACT I AM ENTITLED TO A "CASH BACK" INCENTIVE. THIS
 INCENTIVE IS TO BE ADDED TO MY REGULAR PAYCHECKS FOR THE _____ PAYPERIODS THAT I
 AM ENTITLED TO.

BY WAIVING HEALTH/DENTAL INSURANCE, I MUST PROVIDE PROOF THAT I HAVE OTHER
 MEDICAL/DENTAL INSURANCE COVERAGE.

MEDICAL INSURANCE COMPANY _____
PLAN NUMBER _____
EMPLOYER PROVIDING COVERAGE _____

DENTAL INSURANCE COMPANY _____
PLAN NUMBER _____
EMPLOYER PROVIDING COVERAGE _____

SIGNATURE _____

DATE _____

Office Use

HEALTH INSURANCE COST	
DENTAL INSURANCE COST	
TOTAL SCHOOL DISTRICT COST	
EMPLOYER COST	
# PAY PERIODS	
PAY PERIOD AMOUNT	