HEALTH INSURANCE DECLINATION AND WAIVER

1. I, _____, as an active benefits eligible employee, hereby request to decline and waive enrollment in my Employer sponsored HIP, and EmblemHealth Company medical health insurance plan for: **[Please check one below]**

☐ Myself

☐ Myself AND my spouse and dependents

☐ I am enrolling in my employer's group health plan for myself, but I am waiving coverage for my spouse and dependents.

Reason for waiving: **[Please check one below]**

☐ I am covered through my spouse's employer

☐ I am covered through a parent's employer

Other: _____

2. In making this request, I understand and agree that I and/or my spouse and dependents will not be eligible for Employer provided medical health insurance coverage for which I and/or my spouse and dependents would otherwise be eligible. Notwithstanding anything to the contrary in this form, I understand and agree that if I suffer an involuntary loss of this alternate coverage, I may apply to re-establish Employer provided medical health insurance coverage, as described in Item 3, explained below.

3. I understand and agree that my waiver of medical health insurance coverage shall remain in effect throughout the 2025 plan year from July 1, 2025 through June 30, 2026, unless I suffer an involuntary loss of alternate coverage. In order to enroll in medical health insurance coverage provided by my Employer, I understand that I must complete and submit to the Human Resource Office a request to enroll in the medical health insurance coverage and provide proof of the involuntary loss of coverage or, if during an open enrollment period, state that I am choosing to enroll during the open enrollment period. The effective date of my medical health insurance coverage shall be subject to and conditioned on the requirements of the Employer's medical health insurance plan(s). In addition, I understand that these requirements may be changed at any time.

4. I agree that by signing this waiver I release and discharge Mamaroneck Union Free School District, its officers, directors, employees, agents, Plan Administrator, claims administrator, fiduciaries, and representatives, to the full extent permitted by law, from all actions, causes of action, suits, charges, claims, damages, and complaints that I have or may have against the School District resulting from or relating to my failure to participate in the medical health insurance plan with respect to my employment, including all claims involving the continuing effects of such non-participation, whether known or unknown, asserted or unasserted.

Employee Signature _____

Print Name _____

Date _____