

HEALTH INSURANCE WAIVER FORM 2026 - 2027

TRUMBULL BOARD OF EDUCATION
Trumbull Public Schools



Type of Waiver	
Single	<input type="checkbox"/>
2 Person	<input type="checkbox"/>
Family	<input type="checkbox"/>

THIS FORM IS TO BE COMPLETED IF YOU ARE **DECLINING BOTH THE MEDICAL AND DENTAL COVERAGE** OFFERED BY THE TRUMBULL PUBLIC SCHOOLS FOR THE PLAN YEAR 2026-2027. BASED ON YOUR BARGAINING AGREEMENT/UNION CONTRACT, YOU MAY BE ENTITLED TO A HEALTH INSURANCE WAIVER PAYMENT WHICH WILL BE DISBURSED BASED ON THE DATES OUTLINED IN YOUR UNION CONTRACT. FAILURE TO RETURN THIS SIGNED FORM DURING OPEN ENROLLMENT EACH YEAR WILL DISQUALIFY YOU FROM RECEIVING THE WAIVER PAYMENT FOR THAT YEAR.
YOU MAY ENROLL IN THE VISION COVERAGE AND STILL BE ELIGIBLE FOR THE WAIVER PAYMENT.

Employee Name (Last, First)	<input style="width: 95%;" type="text"/>	EFFECTIVE DATE	7/1/2026
Street Address	<input style="width: 95%;" type="text"/>	EMPL NO.	<input style="width: 95%;" type="text"/>
City, State & Zip	<input style="width: 95%;" type="text"/>	GROUP	<input style="width: 95%;" type="text"/>
Phone No. (Home) *	<input style="width: 95%;" type="text"/>	HIRE DATE	<input style="width: 95%;" type="text"/>
Phone No. (Cell) *	<input style="width: 95%;" type="text"/>	EMAIL	<input style="width: 95%;" type="text"/>

* Please indicate at least 1 phone number optional

Please complete the section below for yourself and all eligible dependents. If we do not already have a copy of your marriage license and/or child(ren)'s birth certificates for all dependents listed below, please forward them to the Insurance Department at Long Hill - Attn: Christine Madden

	NAME (Last, First)	DOB
Employee	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
Spouse	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
Dependent	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
Dependent	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
Dependent	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
Dependent	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>

Are you covered under any TRUMBULL BOARD of EDUCATION or TOWN OF TRUMBULL health plan through your spouse or parent?

YES NO

By signing below, I confirm that I am declining both Medical and Dental coverage for the 2026-2027 plan year

EMPLOYEE SIGNATURE: _____ DATE: _____

Please do not complete below - For Insurance Dept. Use only

	Type	Mos.	FTE	Notes
Employee Only	<input style="width: 30px; height: 20px;" type="text"/>	<input style="width: 30px; height: 20px;" type="text"/>	<input style="width: 30px; height: 20px;" type="text"/>	
2 Person	<input style="width: 30px; height: 20px;" type="text"/>	<input style="width: 30px; height: 20px;" type="text"/>	<input style="width: 30px; height: 20px;" type="text"/>	
Family	<input style="width: 30px; height: 20px;" type="text"/>	<input style="width: 30px; height: 20px;" type="text"/>	<input style="width: 30px; height: 20px;" type="text"/>	