Region 14 Schools
Inspiring Excellence

HEALTH BENEFITS WAIVER FORM

Employee Name:		
Last	*First*	*Middle Initial*
Date of Employment:		
Date of Birth:		

I was given the opportunity to enroll in a group insurance health plan offered by my employer and insured by ConnectiCare.

(Note: Benefits provided on a noncontributory basis cannot be funded.)

I am declining to enroll for the reason shown below:

- ☐ Covered by spouse's group coverage
  Carrier Name and Member ID: _____
- ☐ Enrolled in another Insurance Carrier Plan
  Carrier Name and Member ID: _____
- ☐ Covered by Medicare
- ☐ Other (*Please explain*)_____

I acknowledge I have been given the opportunity to apply for this medical coverage. However, I am electing not to enroll. By declining this group health coverage I acknowledge that I and my dependents (if any) may have to wait until the plan's next anniversary date to enroll for group health coverage.

_____

Employee Signature Date