

***Gloucester City Board of Education***  
**Board Office**

**EMPLOYEE HEALTH BENEFITS  
WAIVER OF  
MEDICAL/PRESCRIPTION DRUG INSURANCE COVERAGE**

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Group Policy: Aetna

Policyholder Name: Gloucester City Board of Education

Employee Name: \_\_\_\_\_ SS#: \_\_\_\_\_

Job Title: \_\_\_\_\_ Location: \_\_\_\_\_

Date of Employment: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I was given the opportunity to enroll myself and my dependents in group medical insurance coverage offered by my employer. On an annual basis, I elect to waive said coverage:

- 1) **Written proof of active insurance coverage under an alternate medical plan is required.**
- 2) This waiver form must be submitted to the Board Office and each waiver will be effective for one year and must be renewed each year if a continued waiver is desired.
- 3) Employees may re-enroll in the medical insurance plan during open enrollment periods or as the result of some other qualifying event\*. Employees who waive coverage and subsequently wish to re-enroll must submit a completed application to the Board Office.

\*Examples of a qualifying event: Exhaustion of COBRA coverage through another employer, termination of employment or coverage eligibility under a spouse's health plan due to a reduction in the spouse's work hours, divorce or legal separation, death of the employee's spouse; termination of the spouse's plan coverage.

\_\_\_\_\_  
Signature of Employee

\_\_\_\_\_  
Date

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**Board Office Use**

\_\_\_\_\_  
Approved                                      Date

\_\_\_\_\_  
Effective Date