Gloucester City Board of Education

EMPLOYEE HEALTH BENEFITS WAIVER
MEDICAL/PRESCRIPTION DRUG INSURANCE COVERAGE
2023-2024

Group Policy: School Health Insurance Fund
Policyholder Name: Gloucester City Board of Education

Employee Name: ______________________________ SS#: ____________________
Job Title: ______________________________ Location: ____________________
Date of Employment: ____________________ Date of Birth: ____________________

I am waiving:
☐ Single ☐ 2 Adult ☐ Parent/Child(ren) ☐ Family

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

Board Office Use

______________________________ ______________________________
Approved Date Effective Date