



washington local schools

individual attention. infinite opportunities.

MEDICAL COVERAGE WAIVER FORM

Section 1: Employee Information

Employee Name:		Group Name: Washington Local Schools	
Date of Birth: (MM/DD/YYYY)	Soc. Security #:		

Section 2: Statement of Refusal

<ul style="list-style-type: none">• After careful review, I have had the medical benefits program presented to me for my participation and I have elected to decline medical coverage.• I understand that by declining coverage at this time, I will not be eligible to elect medical coverage until the next annual open enrollment of the group's policy, or if a qualifying event occurs.

Section 3: Employee Signature

Signature

Date