Sweet Home School District No. 55

1920 Long Street
Sweet Home, OR 97386-2395

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HEALTH CARE COVERAGE WAIVER

Employee Name: _____

Date: _____

School: _____

Position: _____

I acknowledge I have been offered the opportunity to enroll myself and my eligible family members in group health benefits through OEBB with the Sweet Home School District.

I decline enrolling myself or eligible family members in the group health plan coverage because:

☐ I have other medical coverage provided by:

Insurance Company: _____

Policy/Group Number: _____

Through (Employer Name): _____

☐ I do not wish to enroll myself at this time

☐ I do not wish to enroll my eligible family members at this time

Even if you are waiving insurance plans, you are still eligible for our mandatory life insurance and long term disability plans. Please specify the name, relationship and phone number of the person you would like to have as the beneficiary of your life insurance plan.

Beneficiary Name:_____ Relationship:_____ Phone#:_____

Employee Name (please print): _____

Date: _____

Employee Signature: _____