

LUZERNE INTERMEDIATE UNIT
WAIVER OF BENEFIT FORM

*THIS WAIVER FORM MUST BE SUBMITTED NO LATER THAN JUNE 1, FOR
IMPLEMENTATION IN THE PROCEEDING SCHOOL YEAR*

I, _____, _____
Name (printed) Social Security Number

wish to waive coverage on the following benefits:

Hospitalization, Medical-Surgical, Major Medical, Dental and Vision

Hospitalization, Medical-Surgical, and Major Medical

Dental

Vision

The request for waiver of health benefits will be ongoing unless discontinued by the Employee. Such discontinuance must be done at the end of each benefit period (June 30th) unless discontinued earlier for an emergency situation.

The benefit waiver period begins July 1st of each fiscal year and terminates June 30th of the proceeding year.

Employee Signature Date

Business Office Use Only

Approved/Business Office Date

Group Number _____ Plan Type _____
Amount (35%) _____ Pay Location _____
December Payment _____ June Payment _____