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) Type of Contract: family, employee/spouse; employee/children; Single

_____ _____

Date of Birth Social Security Number

wish to waive coverage on the following benefits:

(On reverse side list names, social security numbers and dates of birth of dependents, including spouse.)

_____ 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 _____

Save Print Reset