washington local schools
3505 West Lincolnshire Blvd. • Toledo, Ohio 43606

HEALTH BENEFIT ELECTION FORM

Employee Name _____ Employee ID # _____
(Please Print) (First 5 letters of last name, last 4 digits of S.S.#)

I have elected to participate in Medical/Prescription benefits (either Single or Family coverage) and hereby authorized the above payroll deduction to be taken from my wages on a pre-tax basis. This deduction will automatically cease upon my request for termination of the above mentioned benefit, or upon termination of employment.

This authorization replaces any previous authorization I have made.

_____ Date: _____
(Signature)