WASHINGTON
LOCAL SCHOOLS

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

- 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 _____