AUGUSTA COUNTY PUBLIC SCHOOLS

Waiver of Health Benefits

I acknowledge that I have been offered the opportunity to purchase health coverage for myself and my dependents through my employer.

I decline enrollment at this time because:

- ☐ I do not wish to enroll myself in any type of medical coverage at this time.
- ☐ I do not wish to enroll my spouse or child(ren) in any type of medical coverage at this time.
- ☐ I have other medical coverage provided by:

Insurance company name:		Policy number:	
Through (employer name):			

If you are declining enrollment for yourself or dependents (including your spouse) because of other health care coverage, you may enroll yourself or your dependents in this plan prior to the next open enrollment period (under certain circumstances). To do this, you must have involuntarily lost your other coverage and we must receive your enrollment application within 30 days after your other coverage ended.

I understand that:

- I cannot change this election during the plan year unless I have a qualifying election change event.
- This election replaces any previous elections and will terminate on the earlier of: (1) the end of the plan year, (2) when I am no longer a qualified employee eligible to participate in the plan, (3) Plan termination.
- My employer may reduce or cancel this election if necessary to comply with provisions of the Internal Revenue Code.

Employee Name (print) _____

Signature _____ Date _____