VERNON
PUBLIC SCHOOLS

Robert F. Testa
Assistant Superintendent
(860) 870-6000 ext. 4676

HUMAN RESOURCES

Cindy Schnell
Human Resources Specialist
(860) 870-6000 ext. 4665

INSURANCE WAIVER FORM

Employee Name: _____

Date: _____

Bargaining Unit: _____

Position: _____

I acknowledge I have been offered minimum value, affordable coverage for myself and eligible family members with Vernon Public Schools Group Health Plan.

I decline enrolling myself or eligible family members listed below in the group health plan coverage because:

□ I have other medical coverage

□ I do not wish to enroll myself at this time.

□ I do not wish to enroll any eligible family members at this time.

Printed Name: _____

Date: _____

Signature: _____

I understand that by waiving this coverage I would not be eligible for a subsidy from Access Health (the exchange).

The Vernon Public Schools, in partnership with family and community, is committed to provide a quality education, with high expectations, in a safe environment where all students become independent learners and productive contributors to society.