Saranac Community Schools

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SARANAC COMMUNITY SCHOOLS

MEDICAL INSURANCE WAIVER FORM

I certify that the following statements are true:

- **I elect to waive Employer-provided medical insurance coverage because I have medical insurance coverage through another health care provider.**
- I will notify Employer if this spousal employer medical insurance coverage is terminated for any reason.
- I understand that my election to waive Employer-provided medical insurance coverage cannot be changed until the next open enrollment period, or unless I have an event for which federal regulations permit a mid-plan year election. (More information regarding these situations is available from the Administration Office.)
- I understand Employer is not liable for any expenses relating to:
  - My non-work related injury or illness; or
  - Any injury or illness incurred by my dependents.
- I understand that my pay may be increased because of my election to waive Employer-provided medical insurance coverage. I understand that the amount of this pay increase is based upon the collective bargaining agreement or Board policy that applies to me. I further understand that this additional pay is subject to tax withholdings.

Date: ____________________, 2019

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Employee Signature

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Employee Name (Printed)