

**CT Partnership Plan 2.0
HEALTH INSURANCE DECLINE- WAIVER PAYMENT FORM 2019-2020**

TRUMBULL BOARD OF EDUCATION
Trumbull Public Schools



Type of Waiver	
Single	<input type="checkbox"/>
2 Person	<input type="checkbox"/>
Family	<input type="checkbox"/>

THIS FORM IS TO BE COMPLETED IF YOU ARE **DECLINING BOTH THE MEDICAL AND DENTAL COVERAGE** OFFERED BY THE TRUMBULL PUBLIC SCHOOLS FOR THE PLAN YEAR 2019-2020. BASED ON YOUR BARGAINING AGREEMENT/UNION CONTRACT, YOU MAY BE ENTITLED TO A HEALTH INSURANCE WAIVER PAYMENT WHICH WILL BE DISBURSED BASED ON THE DATES OUTLINED IN YOUR UNION CONTRACT. FAILURE TO RETURN THIS SIGNED FORM DURING OPEN ENROLLMENT EACH YEAR WILL DISQUALIFY YOU FROM RECEIVING THE WAIVER PAYMENT FOR THAT YEAR. **YOU MAY ENROLL IN THE VISION COVERAGE AND STILL BE ELIGIBLE FOR THE WAIVER PAYMENT.**

Employee Name (Last, First)	<input type="text"/>	EFFECTIVE DATE	7/1/2019
Street Address	<input type="text"/>	EMPL NO.	<input type="text"/>
City, State & Zip	<input type="text"/>	GROUP	<input type="text"/>
Phone No. (Home) *	<input type="text"/>	HIRE DATE	<input type="text"/>
Phone No. (Cell) *	<input type="text"/>	EMAIL	<input type="text"/>

* Please indicate at least 1 phone number optional

Please complete the section below for yourself and all eligible dependents. If we do not already have a copy of your marriage license and/or child(ren)'s birth certificates for all dependents listed below, please forward them to the Insurance Department at Long Hill - Attn: Christine Madden

	NAME (Last, First)	DOB
Employee	<input type="text"/>	<input type="text"/>
Spouse	<input type="text"/>	<input type="text"/>
Dependent	<input type="text"/>	<input type="text"/>
Dependent	<input type="text"/>	<input type="text"/>
Dependent	<input type="text"/>	<input type="text"/>
Dependent	<input type="text"/>	<input type="text"/>

Are you covered under any TRUMBULL BOARD of EDUCATION or TOWN OF TRUMBULL health plan through your spouse or parent? YES NO

By signing below, I confirm that I am declining both MEDICAL and DENTAL coverage offered for the 2019-2020 plan year.

EMPLOYEE SIGNATURE: _____ DATE: _____

Please do not complete below - For Insurance Dept. Use only				
	Type	Mos.	FTE	Notes
Employee Only	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2 Person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	