OPEN ENROLLMENT FORM (CERTIFIED STAFF) – BENEFIT PERIOD 7/1/2023 – 6/30/2024
WAIVER OF BENEFITS

To be completed only if you wish to waive your medical, prescription, or dental benefits

Employee Name:	**EID#:**

I voluntarily elect to waive the insurance coverage(s) as indicated below. I understand that by waiving my medical insurance I will receive the stipend in the taxable amount of $67.69 each pay. I further understand that should I waive my prescription and dental insurance that I will not receive a stipend.
Check the insurance(s) you wish to waive:

- ❑ **Medical**
- ❑ **Prescription Drug**
- ❑ **Dental**

If waiving medical coverage, you must list alternative medical coverage below:

Employer Providing Coverage (Name/Address): ____

Name of Insured and Relationship: ____

Insurer/Plan Name/Type: ____ Policy #: _________________

Authorization:

I certify that I have adequate medical coverage elsewhere for myself and my dependents. I agree that if I lose my medical coverage, I will notify the Human Resources office within 30 days from the loss of coverage date and will enroll in a Pennsbury plan. If for any reason, I waive medical coverage and as a result, incur any medical expenses that are uncovered, I recognize that these expenses may be my or my family's personal obligation. I agree that if I have a life event (marriage, death, birth of child, divorce or loss of coverage), I will notify the Pennsbury Human Resources office within 30 days if I wish to change my elections.

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EMPLOYEE SIGNATURE DATE