Summit County Educational Service Center

WAIVER OF HEALTH COVERAGE ACKNOWLEDGEMENT FORM

EMPLOYEE INFORMATION:

LAST NAME	FIRST NAME	MIDDLE INITIAL

ADDRESS	CITY	STATE	ZIP CODE

NOTICE OF ENROLLMENT RIGHTS:

If you are declining enrollment for yourself or dependents (including your spouse) because of other health insurance coverage, you may be able to enroll yourself or dependents in the future provided you request enrollment within 30 days after your other coverage ends, you have a qualifying event or during the open enrollment period starting in October with an effective date of January 1st.

STATEMENT:

On behalf of myself and my eligible spouse and dependents (if any), I hereby waive my option to enroll in the health care plan coverage that is available to me under the Summit County Educational Service Center health care plan for the plan year covering January 1 through December 31. I acknowledge and agree that by making this waiver election, neither me, nor my spouse or dependents, will be entitled to receive reimbursement or payments from Summit County ESC or any provider under the Summit County ESC health care plan for any health care expenses or bills of me or my family.

EMPLOYEE SIGNATURE	DATE

Return form to Human Resources