Amherst County Public Schools

Waiver of Group Medical, Dental and Vision Benefits & Notice of Special Enrollment Rights

Check benefits that you are waiving:

☐ **Medical** ☐ **Dental** ☐ **Vision**

Please complete the following:

Employee Name: _____ _____ _____
(Last) (First) (MI)

For the plan year effective __10_/_01__/_23__ I am waiving coverage for:
(MM/DD/YY)

☐ Myself
☐ Spouse/Domestic Partner
☐ Dependent (s) – Please list names: _____

I am waiving coverage due to:

☐ My preference not to have coverage
☐ Coverage under my spouse's/domestic partner's plan – name of carrier: _____
☐ Other coverage – name of carrier: _____

This other coverage is: ☐ Individual ☐ COBRA ☐ Medicare ☐ TRICARE (formerly CHAMPUS)
☐ Medicaid ☐ Employer-Sponsored Group Plan

Special Enrollment Notice and Certification – *Please review and sign below if you wish to waive coverage*
By signing below, I certify that I have been given an opportunity to apply for coverage for myself and my eligible dependents, if any. I am declining enrollment as indicated above. I understand that I am declining enrollment for myself or my eligible dependents (including my spouse) because of other health insurance or group health plan coverage, I may be able to enroll myself and my eligible dependents in this plan if I lose, or my eligible dependents lose, eligibility for that other coverage (or if the employer stops contributing towards my or my eligible dependents' other coverage).

I understand that I must request enrollment no more than 30 days after the date the other health plan coverage ends (or after the employer stops contributing toward the other coverage). If I do not do so, I will not be able to enroll until my employer's next annual open enrollment period.

In addition, I understand that if I have a newly eligible dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my eligible dependent(s). However, I must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.
I understand that in order to request special enrollment or obtain more information, I should contact my group administrator.

Signature of Employee Date of Signature

Return to your Employee Benefits Group Administrator Do Not Return to Anthem (AVA 1433)