**2019 BENEFIT WAIVER FORM**

**Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NameKey\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

You now have the opportunity to enroll for group medical plan coverage in the Franklin Pierce School District Medical Plan. If you do not enroll yourself and any eligible dependents by September 19, 2019, your next opportunity to enroll will be during the plan’s next enrollment period in January of 2020, unless you qualify for a special enrollment (see below).

**Special Enrollments**

If you are declining enrollment for yourself and/or your dependents (including your spouse) because of other health insurance coverage or group health plan coverage, you may be able to enroll yourself and/or your dependents in this plan if you or your dependents lose eligibility for that other coverage or if the employer stops contributing towards your or your dependent’s coverage. However, you must complete this form indicating that the other coverage is the reason you are waiving coverage under this plan and you must request enrollment within 30 days after your other coverage ends or after the employer stops contributing towards the other coverage.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and/or your dependent(s). However, you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

To request special enrollment or obtain more information, please contact:

Administrative Staff – Cathy Young at 253.298.302 or cyoung@fpschools.org

Certificated Staff – Rhonda Grissom at 253.298.3031 or rgrissom@fpschools.org

Classified Staff – Kristen Desmond at 253.298.3033 or kdesmond@fpschools.org

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Check here if you are covered by other group medical coverage:

* Name of Plan: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Check here is your dependents are covered by other group medical coverage:

* Name of Plan: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* The other coverage is the reason for not enrolling myself and/or my eligible dependents under the Franklin Pierce Schools District Medical plan.

I understand that by not enrolling in plan coverage not, the opportunity to enroll later is limited as explained above.

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Signature Date