Delaware Valley School District
Waiver of Group Health Care Coverage
offering under Healthcare Reform for 2024 Plan Year
January 1, 2025 – December 31, 2025

Employee Name: _____
(First) (Last)
Employee Social Security Number: _____

Effective _____/_____/_____ I am waiving coverage for:
(MM / DD / YYYY)

☐ Myself
☐ Spouse
☐ Dependent(s) – Please list names for each:

_____ _____ _____

_____ _____ _____

I am waiving coverage due to:

☐ My preference not to have coverage

☐ Covered under another plan – _____

Please attach proof of other health insurance (copy of enrollment information or ID card). The other coverage is:

☐ Employer-Sponsored Group Plan ☐ Individual ☐ Medicare ☐ Medicaid
☐ TriCare (formerly Champus) ☐ COBRA ☐ Other

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 HR administrator or Business Manager.

_____ _____
Signature of Employee Date of Signature