ARLINGTON HEIGHTS SCHOOL DISTRICT 25
1200 South Dunton Avenue
Arlington Heights, Illinois 60005

Waiver of Insurance Coverage – Part-Time Teachers

Name _____ Social Security Number _____

Please make the appropriate selections:

_____ I do not want *medical* insurance at this time

Reason for declining (please check the one that applies):

_____ Covered by another plan *Name of insured* _____

Name of Employer _____

Insurance Company/Group # _____

_____ Other _____

I understand that I may choose to elect coverage at a future date in the following circumstances, provided I am still an eligible employee. In addition, if I am choosing Single coverage, I understand that I may only add Family coverage in the following circumstances.

1. During Open Enrollment, which is once per year. Please contact the Benefits Office for information regarding dates.
2. Marriage (enrollment forms must be submitted within 30 days of date of marriage).
3. Birth or adoption of child (enrollment forms must be submitted within 30 days from date of birth or adoption).
4. My dependent's previous health insurance coverage is terminating, and is not terminating for failure to pay premiums or fraudulent cause.

If enrolling outside of the above situations, I may need to provide Evidence of Insurability and will be subject to the Preexisting Condition waiting period.

_____ _____
Signature Date