2027
HEALTH CARE REFORM

EMPLOYEE WAIVER FORM

Company name: Addison Community Schools

Employee name: _____

I understand that by waiving coverage I will not be eligible to enroll until the group's next open enrollment.

Please check the appropriate box below:

___ I have my own individual coverage.

___ I am covered under another group health plan, vision plan or dental plan not offered by this employer (through spouse, self, parent, etc)

___ I do not want coverage offered through this employer.

The information provided above is true and accurate to the best of my knowledge.

_____ _____

Employee Signature Date