WAIVER OF HEALTH INSURANCE FOR MEDICAL, PRESCRIPTION, DENTAL AND/OR VISION PLANS:

In accordance with Alternative Insurance Protection Program, I hereby waive health insurance. It is understood that existing coverage will be terminated as soon as allowed by the plan(s), per effective date on this form.

I am attaching a copy of proof of medical and prescription insurance coverage, other than the plan(s) provided by the Paramus Board of Education.

Following is a complete list of all family members who are currently covered by health insurance, other than plan(s) provided by the Paramus Board of Education:

	Name	Social Security #	Date of Birth
Employee			
Spouse			
Child			
Child			
Child			
Child			

Note: You must notify the Board of Education immediately when any of the above listed family members are no longer eligible for Paramus Board of Education health insurance coverage.

Health insurance coverage will be cancelled until you re-enroll in the policy (policies).

I hereby authorize cancellation of my health insurance coverage through the Paramus Board of Education, effective as soon as permitted by the regulations of the plan(s).

Please check plans you wish to waive

Medical		Dental	
Prescription		Vision	

_____ _____

(Printed Name) (Date Request Is Submitted)

_____ _____

(Signature) (Effective Date of Current Waive)