TRUMBULL PUBLIC SCHOOLS
INSURANCE WAIVER

I am submitting this form:

☐ ***As a New Enrollee***

☐ ***Due to a Life Change***

Per Board/Union Agreement, I hereby waive my _____
(single, two-person, or family)

medical and dental coverage for _____ in the amount of _____.
(***school year***)

Name:_____ Employee ID#:_____
(please print)

Other than self, list names/birthdates of those under waiver. If you have not done so in the past, please provide a copy of your marriage certificate and a birth certificate for each child listed below.

Spouse_____ Date of Birth_____

Name_____ Date of Birth_____

Name_____ Date of Birth_____

Name_____ Date of Birth_____

Name_____ Date of Birth_____

Name_____ Date of Birth_____

Name_____ Date of Birth_____

Signature:_____Date:_____

Please refer to your Union Contract for waiver amounts.
Eligible part-time staff will be pro-rated.