RIVERESIDE SCHOOL DISTRICT
July 2019
BENEFITS' WAIVER FORM

WAIVER OF HEALTH/RX-DRUG COVERAGE

Please complete, sign, date and
return to The Business Office as soon as possible.

Name: _____

Address Line 1: _____

Address Line 2: _____

City: _____ State: _____ Zip: _____

Please check off your selection below:

1. ____I wish to continue my current plan elections
   *Health: _____ Dental: _____ Vision: _____

2. ____ I wish to enroll or change my plan elections
   * Health: _____ Dental: _____ Vision: _____

3. _____ I wish to **waive my coverage
   * Health: _____ Dental: _____ Vision: _____

*If you waive Health Insurance, you are also waiving Rx-Drug coverage. You may not have one line of coverage without the other.

**Health: You must have other Health Ins. coverage to waive coverage from RSD. You must provide either a copy of your Health Insurance ID Card, or if through another employer, such as your spouse, provide a dated letter from that employer stating you have current Health/Rx-Drug coverage on that plan. This information must be presented to The Business Office to allow you to waive Health Ins. under the RSD contract.
If you lose your other coverage you must let The Business Office know immediately.

Signature: (Required)_____ Date: _____
Understand this form will remain in effect / cannot be changed or revoked during Plan Year (through June 30,2020 unless considered change due to change in family status (e.g. legal separation, divorce, marriage, death, birth, adoption, or change in work status/insurance of spouse.)