GOVERNOR MIFFLIN SCHOOL DISTRICT Waiver Form- 2017/2018

Name: Social Security Number:

_____ _ _ __

After careful consideration and review, I elect to waive medical insurance offered to eligible employees by Governor Mifflin School District. I understand that by waiving my coverage, I will be unable to enroll in this plan until either: annual Open Enrollment or within 30 days from a Qualified Life Event. I further understand that failing to have coverage under a qualified medical plan could result in tax penalties under Affordable Care Act.

I understand that if my spouse or dependents have benefits coverage available outside the GMSD plan, I may not elect to cover them and do not qualify for the waiver.

List Family Members for whom you are waiving coverage:

_ _____ __ _____
Self – write name Date of Birth

_ _____ __ _____
Spouse – name Date of Birth

_ _____ __ _____
Child 1- name Date of Birth

_ _____ _ _____
Child 2- name Date of Birth

_ _____ _ _____
Child 3- name Date of Birth

Act 93 Support, AFSCME support, Act 93 Administrators
Check one:

__☐_____ Hired and benefits eligible prior to 7/1/2014 (or 1/1/2016 Act 93 Admin). Waiving benefits for self & dependents; $130.00 per month gross, taxable compensation

__☐_____ Waiving benefits for self (no dependents or spouse) $65.00 per month gross, taxable compensation

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GMEA employees (subject to change pending collective bargaining changes)
Check one:

__☐_____ Waiving benefits for dependents $65.00 per month gross, taxable compensation

__☐_____ Waiving benefits for self (not subject to reimbursement) $0.00

Employee Signature: _____ Date: _____