Akron Public Schools

Human Resources Department
Waiver of Group Coverage

Employee Name: _____ Date of Birth: _____

I understand that I am eligible to participate in group health insurance coverage offered through Akron Public Schools:

Please Check All That Apply:

[ ] I waive my employer's group **health** insurance coverage for myself and my dependents

Reason for Waiving Coverage - Please Check One:

[ ] Covered through spouse's employer [ ] Covered through a parent's employer
[ ] Under 65 Retiree covered by previous employer's insurance program
[ ] Other Please specify: _____

Please Read and Sign Below:

This plan meets requirements of Affordability and Minimum Value. In waiving coverage, I understand that I and/or my dependents may enroll under this plan in the future only as the result of certain qualifying conditions. Examples include, but are not limited to:

- Within 30 days of involuntarily loss of other group coverage
- During an approved open enrollment period

Signature:
The undersigned certifies that, to the best of my knowledge and belief and under penalty of perjury, the information listed above is true and complete.

Employee Signature: _____ Date: _____