FERN RIDGE SCHOOL DISTRICT 28J
WAIVER OF HEALTH COVERAGE

I hereby acknowledge that I was offered the opportunity to elect to participate in my employer's health plan and that I decided not to enroll myself (or my dependents, if applicable) for such coverage.

I understand that the reason for my waiver of this coverage is because of other health coverage, and that I may be able to enroll myself (or my dependents, if applicable) in this plan at a later date prior to the next open enrollment period if such other coverage ends. I understand that I must request enrollment within 30 days after my other coverage ends. I understand that if I don't notify the District within 30 days that I will have to wait until the next open enrollment period (September of each year for an October 1st effective date) to enroll.

In consideration of following my direction not to enroll me in the health plan, I hereby release my employer, its employees, officers, board of directors, and agents from any and all liability associated with my declination of health insurance coverage

I decline enrollment at this time because: ☑ I have other group coverage provided by:

Name of Insurance Carrier: _____

Through: ☐ My other employer ☐ My spouse's employer ☐ My parent's employer
☐ Medicare ☐ Medicaid ☐ Oregon Health Plan
☐ Other (please explain): _____

Policy Number: _____

Attach the following to this Wavier of Health Coverage:
- ☐ A copy of your current health insurance carrier card
- ☐ PacificSource Enrollment and Change Form signed with Section 1, 2 and 5 completed.

I HAVE READ THE FOREGOING WAIVER AND FULLY UNDERSTAND ITS TERMS.

Print Name: _____

Signature: _____ Date: _____

Name of Employer: _____