WAIVER OF GROUP DENTAL AND/OR VISION INSURANCE

Please check the appropriate boxes and fill in all blanks. Any missing or incomplete information will result in the rejection of the waiver and you will be enrolled in the dental and vision plans (Kaiser dental and VSP vision).

Employer Name Woodland School District Employee Name _____

Type of waiver: _____ Kaiser Dental _____ VSP Vision

Persons waiving dental: _____I decline enrollment in Kaiser **dental** for myself and my dependents.

_____ I decline enrollment in Kaiser **dental** for my dependents only

Reason for waiving dental: _____I am married to a fellow Woodland employee and am enrolling as a "spouse" under their plan

_____ I have group dental coverage through another employer

_____I have group dental coverage through my spouse's or domestic partner's employer

_____I have individual dental coverage

_____My dependents have group coverage through another plan

Person waiving vision: _____ I decline enrollment in VSP vision

Reason for waving vision: _____I am married to a fellow Woodland employee and am enrolling as a "spouse" under their plan.

_____I have group vision coverage through another employer

_____I have group vision coverage through my spouse's or domestic partner's employer

_____I have individual vision coverage

Proof of other coverage (must be completed for acceptance of waiver)

My dental and/or vision insurance carriers is/are _____
(insurance company) (policy numbers _____) through
_____ (employer of individual name).

By my signature below, I understand I will not be eligible to enroll myself or my dependents until the nest open enrollment, unless I meet the requirements for a special enrollment as defined by the federal Consolidated Omnibus Reconciliation Act (COBRA). By my signature, I also affirm that the declaration of "other coverage" to be true and accurate.

_____ _____

Employee signature Date

Employer – please retain a copy for your records.