

**OPEN ENROLLMENT FORM (CERTIFIED STAFF) – BENEFIT PERIOD 7/1/2022 – 6/30/2023
WAIVER OF BENEFITS**

To be completed only if you wish to waive your medical, prescription, or dental benefits

Employee Name: _____
Home Address: _____
Position: _____
Work Location: _____
Work Phone Extension: _____

I voluntarily elect to waive the insurance coverage(s) as indicated below. I understand that by waiving my medical insurance I will receive the stipend in the taxable amount of \$67.69 each pay. I further understand that should I waive my prescription and dental insurance that I will not receive a stipend.

Check the insurance(s) you wish to waive:

- Medical**
- Prescription Drug**
- Dental**

If waiving medical coverage, you must list alternative medical coverage below:

Employer Providing Coverage (Name/Address): _____

Name of Insured and Relationship: _____

Insurer/Plan Name/Type: _____ Policy #: _____

Authorization:

I certify that I have adequate medical coverage elsewhere for myself and my dependents. I agree that if I lose my medical coverage, I will notify the Human Resources office within 30 days from the loss of coverage date and will enroll in a Pennsbury plan. If for any reason, I waive medical coverage and as a result, incur any medical expenses that are uncovered, I recognize that these expenses may be my or my family's personal obligation. I agree that if I have a life event (marriage, death, birth of child, divorce or loss of coverage), I will notify the Pennsbury Human Resources office within 30 days if I wish to change my elections.

EMPLOYEE SIGNATURE

DATE