Newtown Public Schools
Insurance Waiver Form

Employee Name (Last, First, MI)

Address (No., Street, Town, State, Zip)

Medical Option

Anthem HSA/HRA

☐ **I understand by electing this option that I am declining health coverage for myself and any eligible dependents.**

Signature required if declining coverage
(By entering my name above I am providing my digital signature)

Dental Option

Anthem Dental

☐ **I understand by electing this option that I am declining health coverage for myself and any eligible dependents.**

Signature required if declining coverage
(By entering my name above I am providing my digital signature)

IMPORTANT NOTICE:

Changes during the plan year are permitted only if a qualified change in family status has occurred. Any requested change must be on account of and consistent with the change in family status. The next open enrollment will be in May 2024 for the plan year beginning July 1, 2024.

Signature **Date**
(By entering my name above I am providing my digital signature)