

**Montclair Board of Education**  
**GROUP INSURANCE WAIVER FORM**

**OPT OUT FORM FOR THE PERIOD**  
**July 1, 2015 to June 30, 2016**

**Medical/RX Benefits Waiver**

I waive my right to participate in the Medical and/or Rx Plan offered by Montclair Board of Education for which I am eligible for the period July 1, 2015 through June 30, 2016.

Medical:

Single Coverage:

2 Adults:

Family:

Parent Child Coverage:

Dental: No Compensation

Applicant must provide copy of currently active insurance card as proof of other coverage:

Carrier Name: \_\_\_\_\_

Policy Number: \_\_\_\_\_

I waive my current coverage effective July 1, 2015 following the 30-day notice requirement in return for a prorated taxable, but not pensionable cash incentive. I understand that I will receive payment in June and January each year. I may re-enroll unconditionally effective each subsequent open enrollment (July and January) and I may also re-enroll immediately if I submit proof of a life status change (e.g. employment, death or disability of a spouse; divorce or legal separation, activation to full-time military status, etc.)

By signing below, I acknowledge that I fully understand the terms of this Group Insurance Waiver Form.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Copy of currently active insurance card on file

\_\_\_\_\_  
Chief Operations Officer