FLASHP
Finger Lakes Area School Health Plan

Medical Insurance Waiver Form

Marion Central School District 2021-22

On behalf of myself and my eligible dependents (if any), I acknowledge that the employer/district has offered me the opportunity to enroll in its medical insurance plan(s) and I hereby waive enrollment in the employer/school district medical insurance plan(s) at this time for the following reason:

- ○ I am covered under another employer-sponsored group health plan as a spouse or dependent
  Please indicate if this is a High Deductible Health Plan _____Yes _____No
- ○ I have individual coverage procured through a broker or a public health insurance Exchange
- ○ I am covered by a government program such as Medicare, Medicaid, TRICARE, etc.
- ○ I am covered under another plan sponsored by a second employer
- ○ Other – Please detail reason _____

If declining to participate in the employer/district medical insurance plan at this time due to other health coverage listed above, please provide the following information:

Print Subscriber Name: _____
Carrier Name: _____
Group/Policy Number: _____

Even though you are declining enrollment at this time, you will be able to enroll in the Marion CSD medical insurance plan during the plan's future open enrollment periods if you remain eligible for insurance through the Marion CSD. In addition, you may be able to enroll at other times during the year if you experience a special enrollment event or other qualifying change in status, such as the birth or adoption of a child, a marriage or divorce, or the loss of other coverage.

Print Employee Name: _____

Employee Signature:_____Date:_____

I affirm that the assertions in this form are true and complete to the best of my knowledge.

Employer Signature:_____Date:_____

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