



Employee name: \_\_\_\_\_

### VPS Benefits Election 2023-2024

Coverage Period: 7/1/2023 - 6/30/2024

## Cancel Insurance Coverage / Waive Offer of Insurance

### ❖ Cancellation of Insurance Coverage

I wish to cancel the insurance policy(ies) to which I now subscribe through Vernon Public Schools. I understand that coverage will end on June 30, 2023.

Please cancel the policies indicated below: (please check the insurance type and the tier of coverage)

- Medical:    \_\_ Single       \_\_ 2 Person     \_\_ Family
- Dental:       \_\_ Single       \_\_ 2 Person     \_\_ Family
- Vision:        \_\_ Single       \_\_ 2 Person     \_\_ Family

Cancel Coverage - Employee signature: \_\_\_\_\_ Date: \_\_\_\_\_

### ❖ Waive Offer of Insurance

I acknowledge that, as an employee of Vernon Public Schools, I have been offered the opportunity to enroll in health insurance coverage for myself and my eligible dependents.

I am declining the offer of insurance at this time. I understand that I may enroll only during the annual open enrollment period or if I experience a qualifying life event during the plan year (i.e., loss of coverage, birth, death, marriage, divorce, adoption, etc.).

Coverage Waiver - Employee signature: \_\_\_\_\_ Date: \_\_\_\_\_

I agree that my electronic signature is the legal equivalent of a manual signature.

**Send form to Barbara Borecky, VPS Human Resources**