NEWARK UNIFIED SCHOOL DISTRICT

Human Resources Department

WAIVER OF MEDICAL/DENTAL COVERAGE FORM

Name		Social Security Number
Address		
City	State	Zip
Phone	Gender	Date of Birth

AUTHORIZATION:
I hereby certify that I have insurance coverage provided elsewhere and therefore waive my rights to receive any medical benefits under this plan. I further understand that the decision to waive my benefits will be in effect until I submit proof of loss of other coverage, re-enroll during the "open enrollment period", or complete a statement of health evidence of insurability and have been accepted by the carrier under the plan. I hold the District harmless for failure to be accepted by the insurance company.

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Employee Signature Date