TRUSTEED PLANS SERVICE CORPORATION

P.O. Box 1894
Tacoma, WA 98401-1894
(253) 564-5850
(800) 426-9786

Member Waiver Form

I. EMPLOYER MUST COMPLETE THIS SECTION AND CHECK APPROPRIATE BOXES:

Group Name	Group Number	Division/Department		Employment Information:
Corvallis School District	45830		☐ Hourly ☐ Salary	Original Hire Date __________ Date of Rehire __________ P.T. to Full Time __________ Hours Worked Per Week __________ Open Enrollment ☐ Yes ☐ No Late Enrollment ☐ Yes ☐ No Special Enrollment ☐ Yes ☐ No
I hereby certify that all employment information specified is accurate and complete: ______________________ Employer Representative ________ Date				**Effective Date** __________ ☐ Hourly ☐ Salary

II. EMPLOYEE MUST COMPLETE THE FOLLOWING : Marital Status: ☐ Married ☐ Single Date Married: ____________________

Subscriber Name (last, first): ____ Phone #: ____________________

Address: ______________________________ City: ____________________ State: _______ Zip: ______________

REFUSAL OF COVERAGE WAIVER: ***If you are declining enrollment for yourself or your dependent (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within thirty days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within thirty days after the marriage, birth, adoption, or placement for adoption (or as otherwise allowed by your plan).***

I and my dependents have been given an opportunity to apply for the group medical, dental, or vision coverage offered by my employer. After serious consideration, I/We have decided to decline enrollment in this plan.

Check person this waiver applies to:	***Check coverage this waiver applies to:***		
☐ Employee	☐Medical	☐ Dental	☐ Vision
☐ Spouse	☐ Medical	☐ Dental	☐ Vision
☐ Child/ren (list names) ____________________	☐ Medical	☐ Dental	☐ Vision

☐ **Covered by another group insurance program or Health Maintenance Organization**.

Employer ____________________ Policy # ______________________________

Name of Insured ____________________ SSN ______________________________

☐ **Covered by Champus or retired Military**.

☐ **Other (please explain)**____

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I understand that if I later wish to apply for coverage under this program, I may only enroll as provided in the Special Enrollment Provision or Open Enrollment Provision of this Plan.

Employee's Signature ____

Employee's Name (please print) ______________________________________

Spouse Signature ____

Date____