2024-2025 Waiver Authorization Form

THIS FORM MUST BE RETURNED TO BENEFITS WITH COPIES OF YOUR INSURANCE CARDS ANNUALLY.

Date: _____

I acknowledge that I have been offered the opportunity to purchase health and prescription drug coverage from Independence Blue Cross, for myself and my eligible dependents through my employer, the Pottstown School District, and

☐ I wish to waive medical insurance; I have other medical insurance provided by:

Insurance company name:

_____

Through (Employer name):

_____

Group or Policy Number:

_____

☐ I wish to waive prescription drug insurance; I have other prescription insurance provided by:

Insurance company name:

_____

Through (Employer name):

_____

Group or Policy Number:

_____

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health care coverage, you may under certain circumstance, in the future enroll yourself or your dependents in this plan prior to the next open enrollment period. To do this, you must experience a qualifying life event and we must receive your enrollment application within 30 days after your other coverage ended. Additionally, 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 eligible dependents, provided that we receive your completed enrollment application within 30 days after the marriage, birth, adoption, or placement for adoption. **I have included copies of my insurance cards.**

Print Name:	Signature