SOUTH GLENS FALLS CENTRAL SCHOOL DISTRICT

WAIVER OF HEALTH INSURANCE

I am waiving my rights to the District Provided Health Insurance Plan for the 2017-2018 school year beginning July 1, 2017 and ending June 30, 2018, in consideration of a cash payment.

I do so willingly and with the knowledge that the District has no responsibility to provide me with coverage for any health related claims for which I would have been reimbursed.

I do so with the knowledge that the waiver is revocable. Upon notification of intent to re-enter the District Health Insurance Plan, coverage will resume on the 1st day of the month following notification provided such notification is made on or before the 10th of the month.

I certify that I am covered by another Health Insurance Plan.

Name:_____
(Print)

Signature:_____

Sworn to before me this _____day
of _____, 2017

_____
Notary Public

- **Proof of Insurance must be attached (copy of current insurance card).**
- **Must be signed in presence of Notary Public. Note: there are 6 notaries at central office.**

Return form to Cheryl Bishop, Administrative Center