



# Pawtucket School Department

School Administration Building  
79 ½ Park Place  
P.O. Box 388  
Pawtucket, RI 02860

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## Business Office & Accounting Department

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### WAIVER OF INSURANCE BENEFITS

To: Pawtucket School Department

From: Employee Name: \_\_\_\_\_ Date: \_\_\_\_\_

Please be advised that my participation in the Group Health Insurance plan(s) provided by the Pawtucket School Department would result in duplicate and unnecessary coverage. Therefore, I am waiving such participation at the present time, with the clear understanding that, for any reason whatsoever, I may join the plan(s) on the first of the month following notice to the Business Office.

I am waiving:  Health & Dental Coverage  Only Health Coverage  Only Dental Coverage

I am currently enrolled in the following health insurance plan:

- Healthmate Coast to Coast  United Health plan  
 Blue Cross/Blue Shield  Medicare  
 Delta Dental  
 Other (Please specify): \_\_\_\_\_

The above coverage is provided to me through the following method:

- My spouse or former spouse's health plan  
 Another employer covers me  
 I have Medicare Part A \_\_\_\_\_ Part B \_\_\_\_\_  
 Other (Please specify): \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Employee Signature: \_\_\_\_\_

Witness Signature: \_\_\_\_\_