



Health Insurance and Dental Coverage Waiver

Name: _____ Social Security Number: _____
Last First MI

Address: _____
Street Apt. City State Zip Code

Contact: _____
Home phone Work phone E-mail

Department: _____

By waiving health insurance, I understand that:

- I will not have another opportunity to enroll until the next open enrollment period or qualifying event; and
- I will receive a payment of \$15 per month for waiving health insurance.

I understand that the County's health plan includes dental coverage. I can waive both the health insurance and dental coverage OR waive the health insurance and enroll **only** in dental coverage.

I do not wish to enroll or to continue enrollment for myself and my eligible family members in a James City County health plan that includes both health insurance and dental coverage

Signature Date

I do not wish to enroll or to continue enrollment for myself and my eligible family members in the health insurance portion of James City County's health plan; however, I wish to enroll in dental coverage. I understand that I need to complete a separate Delta Dental Enrollment Form.

Signature Date

For Current Employees Only:

For COBRA purposes, are you, your spouse, or dependent child(ren) covered by any other health insurance policy?
Yes No

If yes, who does the policy cover? (check all that apply) You Your spouse Your children

Attach evidence of coverage and return to Human Resources.

******* Stop Here and Print *******

Signature Date

Section Below to Be Completed by Human Resource Department

Effective Date: _____