FOR OFFICE USE ONLY

June %_______Payment____________

December %_______Payment________

Benefit Eligible____________________

ELECTION TO NOT ACCEPT HEALTH INSURANCE COVERAGE THROUGH MONROE #1 B.O.C.E.S

I certify that I am covered by other health insurance at this time and do not wish to be covered by the group health insurance offered by BOCES #1

Name of **EMPLOYEE** (Please **Print**)____

Social Security Number of **EMPLOYEE**______________________________________

Person under whom you are covered:____

Employer sponsoring the plan:____

Name of insurance company:____

I understand that by choosing not to accept medical coverage that neither myself nor any of my dependents are covered under my employer's group health insurance plan.

I AGREE TO NOTIFY MONROE #1 BOCES IF THE ABOVE COVERAGE ENDS OR IF I AM NO LONGER COVERED BY ANOTHER MEDICAL PLAN.

Signature:____

Date:______________________

ENCLOSED IS A COPY OF THE HEALTH INSURANCE MEMBERSHIP CARD SHOWING THAT I AM COVERED UNDER ANOTHER PLAN.