

East Jackson Community Schools
EMPLOYEE WAIVER OF HEALTH INSURANCE FORM

Please print:

Employee Name: _____

Assignment Title: _____

_____ I am eligible to receive group health insurance benefits through MESSA.

_____ I am waiving group health insurance coverage through my Employer because I have other group health insurance coverage. The information for my coverage is:

Insurance Carrier Name: _____

Policy Contract Number: _____

Policy Holder Name: _____

Relationship of Policy Holder (self, spouse, parent, etc.): _____

The information printed above is true and accurate to the best of my knowledge.

Employee Signature

Date