WYANDANCH UNION FREE SCHOOL DISTRICT

Medical/Dental Declination Form

I hereby **decline** the following insurance coverage for the **2023-2024** school year:

☐ Medical Coverage
(reimbursement according to contract)

☐ Dental Coverage
(reimbursement according to contract)

☐ **Individual Declination** ☐ **Family Declination**

PLEASE INDICATE THE CBA BELOW

☐ Administrator ☐ Non-Unit Administrator

☐ Teacher ☐ Teaching Assistant ☐ Teacher Aide

☐ Clerical

☐ UPSEU/Maintenance ☐ UPSEU/Food Service ☐ UPSEU/Security

I understand it is **my** responsibility to inform the Human Resources Department at the beginning of **every school year** that I am continuing to OPT OUT of the coverage indicated.

In addition to this form, I have provided a copy of my health insurance card to HR via email/mail

RETURNING STAFF: The Opt Out Form and health insurance card must be received in HR no later than October 1, 2023 or I will forfeit declination reimbursement.

Signature _____ Last 4 digits of SS# XXX-XX-_____

Print Name _____ Date _____