



TOMS RIVER REGIONAL SCHOOLS BOARD OF EDUCATION

1144 Hooper Avenue
 Toms River, New Jersey 08753
 (732) 505-5500

David M. Healy
 Superintendent of Schools

William J. Doering
 Business Administrator

HEALTH INSURANCE WAIVER FORM

I hereby waive health insurance benefits (in which I am currently enrolled/eligible) with the Toms River Regional Schools Board of Education. I understand that this includes medical, prescription, dental and vision coverage. I hereby certify that I am currently married to or a dependent child of a Toms River Regional Schools Board of Education employee and will receive benefits as his/her dependent.

I understand that I will not be compensated for such waiver however I will no longer have Ch. 78 deductions taken from my pay and utilized towards benefits.

I also understand that I may only re-enroll into any eligible coverage during an Open Enrollment period, or upon proof of any qualifying event as defined by the health insurance provider.

Employee Name _____ **DOB** _____
 (Last) (First) (MI)

Home Address _____ **Home Number** _____
 _____ **Cell Number** _____

Personal Email Address _____ **School/Work Location** _____

Insured Spouse/Parent Name _____ **Effective Date of Waiver** _____

Current Contract Type: Single Emp/Spouse Emp/Child(ren) Family

Please List all Persons who will be Covered under your Spouse's/Parent's insurance plan with TRRS:

Name (Last, First, MI)	Relation (Spouse/Child)	Gender (M or F)	DOB (Mo/Day/Year)

I certify that the information presented on this form is true and correct.

Employee Name - Waiving Coverage (Print) **Employee Signature** **Date**

Insured Spouse/Parent Name (Print) **Insured Spouse/Parent Signature** **Date**

Office Use Only:			
Rec'd TRBOE _____	Added to Spreadsheet _____	Payroll Notified _____	
Emp SS# _____	Position/Loc _____	Unit _____	Salary _____
Sp/Parent SS# _____	Position/Loc _____	Unit _____	Salary _____