Sweet Home School District No. 55

1920 Long Street
Sweet Home, OR 97386-2395

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HEALTH CARE COVERAGE WAIVER

Employee Name: ______________________________

Date: ____

School: __________________________________

Position: ____________________________________

I acknowledge I have been offered the opportunity to enroll myself and my eligible family members in group health benefits through OEBB with the Sweet Home School District.

I decline enrolling myself or eligible family members in the group health plan coverage because:

☐ I have other medical coverage provided by:

Insurance Company: _______________________________________

Policy/Group Number: _____________________________________

Through (Employer Name): _________________________________

☐ I do not wish to enroll myself at this time

☐ I do not wish to enroll my eligible family members at this time

Printed Name: _________________________________

Date: ____

Signature: ___________________________________