Olentangy Local School District
Benefits Selection and Waiver Form

Please complete the General Information section and indicate your selection of coverage for each benefit offered below. Note: The appropriate enrollment form(s) must be completed for each type of coverage. *If you WAIVE any benefits at this time, please also complete the acknowledgement on the reverse of this form.

GENERAL INFORMATION	
LAST NAME	FIRST NAME
SOCIAL SECURITY NUMBER - -	EFFECTIVE DATE / /

√ Plan Description (select one)

	MEDICAL INSURANCE
	Yes, I elect Medical Insurance Coverage
	Waive Medical Insurance Coverage*

	DENTAL INSURANCE
	Yes, I elect Dental Insurance Coverage
	Waive Dental Insurance Coverage*

	VISION INSURANCE
	Yes, I elect Vision Insurance Coverage
	Waive Vision Insurance Coverage*

	LIFE INSURANCE
	Yes, I elect Life Insurance Coverage
	Waive Life Insurance Coverage*

	OPTIONAL ADDITIONAL LIFE INSURANCE
	Yes, I elect Medical Insurance Coverage
	Waive Medical Insurance Coverage

I hereby acknowledge and agree that I have read and understand the contents of the Benefits Notice and authorize the above health insurance elections.

_____ _____

Employee Signature Date

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WAIVER OF HEALTH CARE COVERAGE DURING INITIAL ENROLLMENT

I am an employee of Olentangy Local School District ("Employer").

I understand that I am eligible to elect health care coverage for myself and my eligible family members under the Employer's Health Plan during my Initial Enrollment Period and for the remainder of the Plan Year. The Plan Year begins on January 1 and ends on December 31.

I understand that my Initial Enrollment Period begins on the first day of the month after my date of hire and ends 31 days after that date.

I understand that if I elect health care coverage for myself and my eligible family members during my Initial Enrollment, the health care coverage would begin the first day of the month following my date of hire.

If I decline health care coverage during my Initial Enrollment Period, I understand that I will not be eligible to elect health care coverage until the Open Enrollment Period for the next Plan Year, unless I have a change in status event which permits a mid-year election of health care coverage. The Open Enrollment Period is generally held from November 1 – November 30 each year with a January 1 effective date. The terms of the Employer's Health and my Employer's section 125 plan govern if a mid-year election is permissible.

By signing below I acknowledge I have been offered coverage but have chosen to **DECLINE** health care coverage for myself and/or my eligible family members for the upcoming plan year. I understand it is my responsibility to notify the district within 31 days of a qualifying event should I chose to elect coverage in the future.

_____
Signature of Employee

_____
Printed Name of Employee

_____
Date