

Support Staff Opt Out Election Form

This is to acknowledge that I have been given the opportunity to enroll in Saucon Valley School District's medical/rx/dental/vision plans. I am choosing to waive this coverage and understand that I will not be eligible to re-enroll in Saucon Valley School District's medical/rx/dental/vision plans until open enrollment. If you choose to re-enroll during the open enrollment period, your coverage will become effective July 1, the start of the new school year.

Date: _____

Signature: _____

Print Name: _____

Please provide proof of insurance below, also provide copies of insurance cards
Insurance Carrier:
Policy Number:
Employer: