Lewiston-Porter Central School District
Declination of Coverage Form
2023-2024 School Year

Employee Name: Last First Middle		Social Security Number XXX-XX-
Address Street City/Town State Zip Code		
Date of Birth	Phone No: ( ) -	Unit

☐ I am declining Employee Coverage.

I certify that I have been given the opportunity to participate in the group health insurance plan offered by my employer and have declined to participate. I have declined to participate because I currently have coverage through (check one):

☐ My spouse's group coverage

☐ An Individual Plan

☐ A government plan (type) _____

☐ Cobra or State Continuation

☐ Other (explain) _____

☐ I and/or my dependents are currently not covered by any other health benefit plan

I understand that if I elect to decline coverage for myself, my spouse, and/or my dependent children through this employer health benefit plan at this time, I can only join at a later date with a qualifying event, or I will need to wait until the employer's next open enrollment period (approximately May 1 – May 31, 2024).

You must include a copy of your proof of current coverage in order to be eligible for the health insurance buyout. Long-term Substitutes are not eligible for the buyout but must still fill out this form if they are declining the coverage.

Signature of Employee: _____ Date: _____

Lewiston-Porter Central School District
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