SCHOOL COMMITTEE

MEDICAL INSURANCE WAIVER July 1, 2024-June 30, 2025

Employee's Name: _____

I request to waive my medical/dental insurance benefits as provided by the City of Pawtucket in return for the following payment:

Please check coverage(s) you are waiving:

Medical:	**Individual ( )$ 500.00**	**Family:( )$ 1,500.00**	**( ) No Stipend**
Dental:	**Individual ( ) $ 50.00**	**Family: ( ) $ 150.00**	**( ) No Stipend**

The amount of waiver will be: _____

- This waiver is effective for twelve (12) months only must be renewed annually.
- If I need to reinstate medical coverage, I must notify the HR Department at least thirty (30) days in advance.
- I understand that the open enrollment period for all medical plans is June 1st to June 30th.

Medical/Dental waiver payment(s) will be included in employee's last paycheck in November.

I understand and agree that having received this medical reimbursement, if I subsequently enroll in medical or dental coverage with the City of Pawtucket before the end of the fiscal year, or if I shall no longer be employed by the City of Pawtucket before the end of the fiscal year, I shall repay to the City of Pawtucket on a pro-rated basis, monies which I have received for said waiver. This agree that this amount is payable to the City of Pawtucket within thirty (30) days of either coverage reinstatement or termination of employment or, at the option of the City, I agree that it may be deducted from my pay.

I certify that I have alternative medical insurance coverage and I am not covered by the Affordable Care Act at Healthsource RI or any other State or Federal agency.

Signature: _____

Date: _____