

# MONTGOMERY COUNTY R-II SCHOOL DISTRICT

**WAIVER**  
**FOR**  
**DISTRICT PROVIDED HEALTH INSURANCE**

I, the undersigned employee of Montgomery County R-II School District, do hereby and by my signature on this document, waive and refuse my participation and benefits in the Montgomery County R-II School District group health insurance program.

I understand that this is a benefit provided by the Montgomery County R-II School District for its employees. I understand that at this time this benefit is provided to me as an employee without cost as the District pays the employee premium in whole.

I understand that this benefit, if refused, will impact my state retirement plan as the premium paid by the District for each of its employees is currently counted as creditable earnings on my yearly salary reported to the state retirement agency.

I understand that as a requirement for this waiver to become effective, I must show proof of health insurance that is currently in force.

I understand that this waiver, when effective, may not allow me to participate in the Montgomery County R-II group health insurance plan in the future, if needed, except at a time period of open enrollment for District employees.

I hereby waive and refuse to participate in the Montgomery County R-II School District group health insurance plan.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Attest

I, whose signature is attesting, confirm that the employee signed this document in my presence and that they showed evidence of health insurance as noted below.

\_\_\_\_\_