HAZLETON AREA SCHOOL DISTRICT

WAIVER OF BENEFIT FORM - ESPA

This waiver form must be submitted no later than November 20, 2026 for implementation of waiver for period January 1, 2027 to December 31, 2027. This request of waiver of health benefits will be ongoing unless discontinued by the employee in writing. Such discontinuance must be done to be effective January 1, 2027 unless an emergency situation arises. You are not permitted to waive benefits if you are enrolled in coverage with the Hazleton Area School District. By signing this form you are affirming that you are not receiving benefits through the Hazleton Area School District for which you are waiving below.

Please note: district employees are required to complete a new insurance waiver form each year.

Please complete and return this form to the Business Office.

I, _____ , wish to waive coverage for the following benefits and do solemnly swear (or affirm) the accuracy of the following information and I wish to make a binding election to waive the Hazleton Area School District coverage below:

_____Medical, Dental and Vision (all) _____Medical (only) _____Dental (only) _____Vision (only)

Date of Hire: _____ Job Title: _____

Level of coverage waived:

Individual _____ Employee and Spouse _____ Parent / Child _____ Parent /Children _____ Family _____

Please list name, relationship and date of birth for those dependents that coverage is being waived.

_____

_____

Please list the provider of other insurance:

Name of Other Employer _____ Name of Carrier _____

Name of Policy Holder _____ Plan or Group Identification No. _____

The statement of facts above is true and correct to the best of my knowledge, information and belief. Further, I understand that if any of the above indicated situations change, I have an obligation to notify the HASD Business Office within two (2) weeks of said occurrence. I acknowledge that any costs incurred by the District, from my failure to properly notify the Business Office of the status change, will necessitate be being responsible for all costs and or expenses. I understand that false statements herein are made subject to the penalties of 18 Pa.C.S.A., Section 4904, relating to unsworn falsification to authorities.

_____ _____

Employee Signature Date

Business Office Use Only

_____ _____

Approved/Business Office Date

Waiving Level _____ Amount _____

December Payment _____ June Payment _____