YOUGH SCHOOL DISTRICT
HEALTH INSURANCE WITHDRAWL/BUYOUT

SECTION 1: To be completed by the Yough School District employee waiving Health Insurance Coverage.

Employee Name_____ Payroll #_____

I request that Yough School District cancel my insurance with the district insurance carrier.

_____
Please Initial

For the Dental and Vision plans, please indicate your choice:

	Waive	Keep
Dental	_____	_____
Vision	_____	_____

Note: Keeping or electing the Buyout of Dental and/or Vision will not affect your Buyout Amount.

Employee Signature _____ Date _____

Section 2: To be completed by employer providing medical coverage for Yough School District employee:

I certify that _____has group medical coverage (Name of Yough School District Employee) please print

provided by the employer named below:

Name of Employer: _____

Medical Plan Name: _____

Effective Date of Coverage: _____

Employer Signature _____ Date _____

Return completed form to the Business Office.