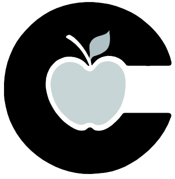
Human Resources Department – Benefits Office



2022-2023 Group Health Benefits Waiver

For the plan year effective September 1, 2022, I am waiving coverage for (select any that apply):

☐ Myself ☐ My spouse ☐ My dependent(s)

If selecting dependent(s), please list the name(s):____

____

I am waiving coverage due to (select one):

☐ Coverage under my spouse's plan ☐ My preference not to have coverage ☐ Other coverage

This other coverage is (select any that apply):

☐ COBRA	☐ Employer-sponsored group plan	☐ Exchange plan with subsidy	☐ Exchange plan without subsidy
☐ Individual Policy	☐ Medicaid	☐ Medicare	☐ Miscellaneous
☐ SHOP plan	☐ TRICARE	☐ I choose not to have coverage	

Special Enrollment Notice and Certification

By signing below, I certify I have been given an opportunity to apply for group health coverage for myself and my eligible dependents, if any. I am declining enrollment as indicated above. I understand that, if I am declining enrollment for myself and any eligible dependents (including my spouse) because of other health coverage, I may be able to enroll myself and my eligible dependents in this plan if I lose, or my eligible dependents lose, eligibility for that other coverage (or if the employer stops contributing towards my or my eligible dependents' other coverage).

I understand I must request enrollment no more than 30 calendar days after the date the other health coverage ends (or after the employer stops contributing toward the other coverage). If I do not request enrollment in this time frame, I will not be able to enroll until my employer's next annual enrollment period.

In addition, I understand that if I have a newly eligible dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my eligible dependent(s). However, I must request enrollment no more than 30 calendar days after the marriage, birth, adoption, or placement for adoption.

I further understand that in order to request special enrollment or obtain more information, it is my responsibility to contact my employer's benefits office.

_______________________________________ _______________________________

Printed Name **Employee Identification Number (EIN)**

_______________________________________ _______________________________

Signature **Date**

Please return the completed form to the CISD Benefits Office using **one** of the following options:

Email:
benefitsoffice@conroeisd.net

- OR -

Fax:
936-709-9106

- OR -

Mail:
Benefits Office – Human Resources Department
Conroe Independent School District
3205 W Davis St, Conroe, TX 77304