WAIVER OF GROUP HEALTH COVERAGES

Complete this form if you are waiving any PSRS-sponsored coverages (medical, dental or vision) for yourself or an eligible dependent

I acknowledge that I am eligible for group medical, dental or vision coverage sponsored through the Public School Retirement System of the City of St. Louis (PSRSSTL), provided I agree to contribute to the cost of such coverage, if any, at required contribution rates.

I DO NOT wish to enroll myself and/or my dependents in the following coverages as indicated below:

			Waiving		
Name	**Relation**	**Date of Birth**	**Medical**	**Dental**	**Vision**
	Self		☐	☐	☐
	Spouse		☐	☐	☐
	Child		☐	☐	☐
	Child		☐	☐	☐
	Child		☐	☐	☐
	Child		☐	☐	☐

I am declining coverages for the following reason(s) *(check each option that applies)*:

☐ I am electing coverage through another group employer plan or a state Medicaid insurance program;

Company Name or Plan Sponsor: _____

☐ I am enrolling in individual medical coverage through Healthcare.gov;

☐ I am enrolling in an individual Medicare Supplement or Medicare Advantage plan;

☐ I have dependents; however, I am declining or electing not to enroll eligible dependents for the coverages noted above through PSRSSTL. My dependents have a similar type of group employer coverage through another source.

Company Name or Plan Sponsor: _____

☐ Other (explain) _____

NOTE: *If you are declining enrollment for yourself or your dependents (including your spouse) because you have other group employer or state Medicaid health insurance coverage, you will, in the future, be able to enroll yourself and your dependents in a PSRSSTL-sponsored medical, dental and/or vision plan provided you request enrollment within 60 days after your other group or state Medicaid coverage has been involuntarily terminated.*

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll the dependent(s) in a PSRSSTL-sponsored medical, dental and/or vision plan provided you request enrollment within 60 days after the date of the event.

All enrollments must include appropriate documentation confirming proof of coverage loss as well as proof of dependent eligibility.

Please refer to the Group Insurance Enrollment Policy and the Dependent Eligibility for Medical, Dental and Vision Coverage policies which can be located on the Public School Retirement System of the City of St. Louis' website: www.psrsstl.org/health-insurance/.

_____	_____
Retiree's Name ***(Please print)***	Social Security Number
_____	_____
Street Address	Telephone Number
_____	
City, State and Zip Code	
_____	_____
Signature	**Date**