WALLINGFORD SWARTHMORE
SCHOOL DISTRICT

Seniority Step Election

Consistent with the bargaining unit agreement between the Wallingford-Swarthmore Education Association and the Board of School Directors (2005-2010), I hereby apply for disenrollment from the medical, prescription, and dental insurance plan for myself and my dependents as listed below. I understand that my Step 16 salary will increase by the amounts listed in the below table.

2005-06	2006-07	2007-08	2008-09	2009-10
$4,200	$4,100	$4,000	$4,000	$4,000

_____ _____
NAME (please print) DATE

_____
BUILDING

VERICATION OF OTHER MEDICAL COVERAGE

ALTERNATE COVERAGE PROVIDED BY _____
(Name of Insurance Provider)

POLICY/GROUP OR IDENTIFICATION # _____

Name	DOB	Student	Personal Choice	HMO	Dental

_____
SIGNATURE

Disenrollment accepted by _____ Date _____

Distribution: White – Human Resources Yellow – Employee

Ems: Revised 10/05