

WALLINGFORD SWARTHMORE

SCHOOL DISTRICT

200 SOUTH PROVIDENCE ROAD, WALLINGFORD, PENNSYLVANIA 19086-6334

Disenrollment from Medical, Prescription, and Dental Insurances

Consistent with the Collective Bargaining Agreements or Compensation Plan of the Wallingford-Swarthmore School District, I hereby apply for disenrollment from the medical, prescription, and dental insurance plans which would also include my dependents. I understand that this Disenrollment remains in effect for an entire plan year, or until an Open Enrollment, or until a Qualifying Event.

Please check your employee classification:

Administrators _____ Confidential Secretaries _____ Exempt Supervisors _____
Non-Certificated Nurses _____ Teamsters _____ WSESPA (Support Staff) _____
WSEA _____

PRINT NAME _____ DATE _____

In order to disenroll, you must present evidence of coverage elsewhere by completing the following:

Alternative Coverage Provided By: _____
(name of insurance provider)

(policy/group number or ID)

EMPLOYEE SIGNATURE _____

For Office Use:

Disenrollment accepted by _____ Date ____/____/____
Payment in four equal installments included in paychecks or contributions to a TSA on paydays closest to September 30, December 30, March 30, June 15.

Charge to budget code _____.

Disenrollment from ____/____/____ through ____/____/____.

Distribution: White - Personnel Office

Yellow - Payroll

Pink - Employee