

Washoe County School District Request for Waiver of Insurance Benefits

As an employee of Washoe County School District, I am requesting a waiver of the "District- paid" portion of my health premium. This covers my medical, dental, vision, and life insurance while I am in unpaid status and on leave due to my own personal medical restrictions. I will also provide a letter from my doctor stating that I have a reasonable prognosis of returning to work within 6 months.

By initialing, you attest that you are not receiving any other income from employment:
(please initial if applicable)

I understand that I will be notified by Risk Management if my request for a waiver of contributions for insurance benefits is approved. I further understand that I am responsible for any premium charged for the dependent coverage and supplemental life insurance. Checks are made out to: "WCSD Health Insurance Fund" and mailed to PO Box 30425, Reno, NV 89520-3425. Payments are due by the first of each month or on the first pay date that I am in an unpaid status. I will contact American Fidelity at 775-829-1313 to arrange payment for any optional benefits that I may have.

Name (printed):

SS#

Signature:

Phone #

RISK MANAGEMENT USE:

Date:

E#:

Cert:

Class:

Plan:

GL#:

Leave Dates -From:

To:

Extend:

Med:

Den:

Vision:

Life:

Last pay date:

FMLA end date:

Gap:

EE Prem total:

WOP Start:

To:

Extend:

Dependent Prem Total:

Approval Signature:

Date:

Date WOP Expires:

Has employee had a WOP before: No ☐ Yes ☐ If Yes, total number of days in previous 3 years

Status: F=FMLA; P=Paid; W=WOP

	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec
EE												
DEP												