HEALTH DECLINATION REQUEST

Date: _________________

To: Hempstead School District Human Resources

From: ____________________________________
(Employee Name)

School/Location: _____________________________

Social Security Number: _______________________

As of ___________ I am officially declining to participate in the School Health Insurance Program,
(date)
which I am entitled to participate in accordance with the negotiated agreement of

____________________________. I am enclosing proof of my alternative coverage.
(Name of Bargaining Unit)

_________________________________ _______________________
(Employee Signature) (Date)

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Benefits Department: (approved for payment pending verification)

DECLINATION **OPT-OUT**

Proof of Coverage: ( ) YES ( ) NO

Personnel Department:

Employment Eligibility Verified: ( ) YES ( ) NO

District Health Coverage Cancelled Or Not Provided: ( ) YES ( ) NO

Director Of Human Resources: _________________________________ Date: ___________
(Signature)

PLEASE RETURN DECLINATION TO THE OFFICE OF HUMAN RESOURCES
185 Peninsula Blvd
Hempstead, NY 11550