SCHOOL YEAR 2023 - 2024

Woonsocket Education Department
Woonsocket, Rhode Island

Blue Cross / Delta Dental / VSP Waiver

Name: _____ School Bldg._____

Address: _____ Coverage Waived From: **9-1-23**

City, State, ZIP: _____ To: **8-31-24**

I agree to waive my rights to Blue Cross/Blue Shield and/or Delta Dental coverage as provided by the contract for the 2023/24 school year.

a) I waive my **Blue Cross/Blue Shield, Delta Dental and VSP** coverage.

_____
Employee's initials

b) I waive my **Blue Cross/Blue Shield** coverage.

_____
Employee's initials

c) I waive my **Delta Dental** coverage.

_____
Employee's initials

d) I waive my **VSP** coverage.

_____
Employee's initials

1. **This signed authorization must be received by the Woonsocket Education Department, Benefits Dept., 108 High Street, Woonsocket, R.I. 02895, no later than September 1, 2023.**

2. This waiver will automatically be effective for twelve months and **must** be renewed annually.

3. If your spouse quits or loses his/her job at any time during the year, you must notify the Benefits Department immediately if you wish to reinstate your coverage.

_____ _____

Date Employee's Signature