

SHAMOKIN AREA SCHOOL DISTRICT
WAIVER OF INSURANCE BENEFITS

PROFESSIONAL

SCHOOL YEAR-2018-2019

I, _____ do hereby waive my coverage of hospitalization, dental, prescription and vision insurance for the school year 2018-2019 covering the period of July 1, 2018 through June 30, 2019. For this waiver, I shall receive the gross sum of One Thousand (\$1,000) Dollars payable during the last scheduled pay period of June 30, 2019.

I further understand that I retain the right to reinstate my benefits on the first day of any month during the year in question provided there is just cause. It is understood that reinstatement shall mean an automatic forfeiture of the entire stipend.

This form must be renewed annually to remain in effect. Life Insurance is not included in stipend; therefore, a life insurance form must be completed when hired if you are taking a stipend.

PLEASE SIGN AND RETURN IMMEDIATELY TO THE BUSINESS OFFICE.

Signature_____

Date_____