LABRAE LOCAL SCHOOLS | INSURANCE OPTIONS

Check (✓) your bargaining unit: ☐ **Certified** ☐ **Classified**

Choose ONE section below: WAIVE/OPT OUT or INSURANCE COVERAGE.
Then make THREE selections: ONE for Medical/Rx, ONE for Vision, and ONE for Dental

WAIVE/OPT OUT OF INSURANCE

In accordance with my Union's Negotiated Agreement, ***I am waiving insurance coverage*** *for the 2026-2027 school year and requesting the applicable incentive payment.*

For each row, check (✓) ONE box only. Select the coverage level you are eligible to receive **if you were** enrolled in that insurance. DO NOT CHECK MORE THAN ONE BOX IN THE SAME ROW.

	SINGLE	EMPLOYEE/SPOUSE	EMPLOYEE/CHILD	FAMILY
Medical/Rx				
Vision		Vision & Dental coverage levels are **Single or Family**. Employee/Spouse and Employee/Child = Family.		
Dental				

INSURANCE COVERAGE

I wish to enroll or keep my current insurance coverage *for the 2026-2027 school year and refuse the incentive payment for non-use of insurance.*

Complete all THREE rows below. Check (✓) ONE box per row.

	SINGLE	EMPLOYEE/SPOUSE	EMPLOYEE/CHILD	FAMILY
Medical/Rx				
		Employee/Spouse, Employee/Child, or Family Medical/Rx coverage requires a completed Coordination of Benefits (COB).		
Vision		Vision & Dental coverage levels are **Single or Family**. Employee/Spouse and Employee/Child = Family.		
Dental				

☐ **I have completed ONE section above and made ONE selection for Medical/Rx, ONE for Vision, and ONE for Dental. I understand incomplete or incorrectly marked forms will be returned for correction.**

SIGN EMPLOYEE NAME _____ **PRINT EMPLOYEE NAME** _____ **DATE** _____

Call Jessica Cowger at extension 6025 if you…

- ☐ Are newly waiving/opting out of insurance
- ☐ Are newly enrolling in insurance
- ☐ Have a change in your spouse/dependent's employment or insurance coverage
- ☐ Have questions about which coverage to select

Once completed, please return to the Treasurer's Office through interoffice mail immediately.