# MONTICELLO CENTRAL SCHOOL DISTRICT

# DECLINATION OF HEALTH INSURANCE

# SCHOOL YEAR 2025-2026

I do not want to enroll, at this time, under any option of the New York State Health Insurance Program. I understand that by declining to enroll at this time:

1. I may subject myself and/or my eligible dependents to certain applicable waiting periods if I decide to enroll at a later date.

2. I understand that the buy-out period begins July 1st and ends June 30th of every year. By declining to enroll at this time I am forfeiting my right to such coverage until July 1st of the next year.

3. I understand if I am eligible and wish to participate in the buyout program, I must attach proof of other insurance coverage.

**I understand that if I wish to enroll in the Health Insurance Program at the end of the buy-out year, I must elect coverage by April 30th of the said year for coverage to take effect July 1st.**

**Name: (Please Print)** **Social Security #**

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**Signature:** **Date:**

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