

Western Suffolk BOCES

Health Waiver - Return to Benefits Office

Name: _____

Date of Retirement: _____

This is to inform you of my intent to decline the following health insurance coverage for the 2026 calendar year

Based on my status I am eligible for the following coverage. Individual Family

I currently decline medical insurance and wish to decline again in 2026. Yes No

By submitting this form, the above-named retiree attests to the following:

I understand that I may be asked to provide proof of coverage for myself and for all individuals for whom I shall claim a personal exemption deduction for during the 2025 taxable year.

I understand that this election is for one year only and that I must submit proof of alternative coverage for myself and all individuals for whom I shall claim a personal exemption on an annual basis to continue to receive an opt-out payment.

I understand that if Western Suffolk BOCES knows or has reason to know that I or any individual for whom I shall claim a personal exemption deduction do not have or will not have alternative coverage, the opt-out payment WILL NOT be provided to me.

Name of Insurance Currently Covered Under:

List first and last name of all individual covered under your existing medical insurance as well as their relationship to you:

Dependent Name:	Relationship:
_____	_____
_____	_____
_____	_____

Signature: _____

I understand that by signing this form I am attesting that all information above is accurate for purposes of this opt-out form.