WAIVER OF DENTAL AND/OR VISION INSURANCE PLANS:

I hereby waive in dental and/or vision insurance. It is understood that existing coverage, if any, will be terminated as soon as permitted by the regulations of the plan(s) and the Paramus Board of Education.

Following is a complete list of all family members who are currently eligible for this coverage:

Employee Name	Date of Birth	Social Security #

	Name	Dental Waive	Vision Waive	Date of Birth
Spouse				
Child				
Child				
Child				
Child				

NOTE: You must notify the Human Resources Benefits Department immediately when any of the above-listed family members are no longer eligible for Paramus Board of Education dental and/or vision coverage.

______________________________ ________________________
(Printed Name) (Date Request Is Submitted)

______________________________ ________________________
(Signature) (Effective Date of Change)