COMPLETE THIS SECTION ONLY IF YOU WISH TO WAIVE PART OF THE COVERAGE OFFERED

Employee Name: _____ **Social Sec. Number** _____

Employer: STREETSBORO CITY SCHOOLS

Waiver: I hereby certify that I have been given an opportunity to participate in the Employee Benefit Plan. The benefits of the plan have been thoroughly described to me, and I decline to participate. I understand that if, at a future date, I wish to apply for the benefits so waived, I may do so only as designated by the Plan Document.

Waiver of Coverage for: ☐ Medical ☐ Dental ☐ Prescription **Reason for Waiving** _____

Signature of Employee _____ **Date Signed** _____

Signature of Employer _____ Date Signed _____

LIFE INSURANCE

Full Name of Beneficiary(ies):	**Address:**
Relationship:	
Contingent Beneficiary:	**Address:**
Relationship:	
Signature of Employee:	**Date:**

INSTRUCTIONS FOR NAMING BENEFICIARY

1. Give complete name of beneficiary and relationship to you (indicate "non-relative" and present address).
2. If beneficiary is a married woman, show given name (Mary J. Doe not Mrs. John Doe).
3. Unless otherwise provided, proceeds will be paid in equal shares to those primary beneficiaries who survive you, but if no primary beneficiaries survive you, such proceeds will instead be payable in equal shares to those contingent beneficiaries who survive you.

NOTE: You may change your beneficiary at any time in accordance with the conditions and provision of the group policies. You must complete a new enrollment card when changing beneficiaries.