Streetsboro City Schools

MEDICAL INSURANCE PROGRAM

WAIVER FORM

As an employee of Streetsboro City Schools, I ______________________________
(print name)

choose not to participate in the health insurance coverage program, as outlined in the Master Agreement applicable to my present job classification for the contract year 2020-21.

I understand I must meet all conditions set forth by the Portage Area Schools Consortium to come back into the health insurance program.

______________________________ ______________________________
Signature Date