City of DuPont

WAIVER OF INSURANCE COVERAGE

I hereby waive my eligibility for the following insurance coverage from the City of DuPont:

A. Medical insurance coverage for:

□ myself □ my spouse □ my dependents

B. Dental insurance coverage for:

□ myself □ my spouse □ my dependents

C. Vision Insurance Coverage for:

□ myself □ my spouse □ my dependents

D. Life Insurance Coverage for:

□ myself □ my spouse □ my dependents

E. Long-term disability for:

□ myself □ my spouse □ my dependents

I have other insurance coverage through:

Name of Insurance Company:	Effective Date:
Type of Insurance:	Policy Number:

_____ _____

Name of Employee Date

_____

Signature