THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA
DECLINATION OF MEDICAL COVERAGE AFFIDAVIT

I hereby certify that:

1. I have been given an opportunity to fully participate in the group medical plans provided through the School Board of Broward County, Florida.

2. The benefits of the plans have been thoroughly explained to me, and I **decline** to participate. (NOTE: in order to choose to "decline coverage" under the medical plan, you must provide proof of your other medical coverage and have this affidavit **signed and notarized**.)

   I understand that if I desire to apply for medical insurance at a later date, I enroll **only** during an annual enrollment period determined by the School Board of Broward County, Florida or during a "special enrollment period."

   A "special enrollment period" is available if you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage. You may in the future be able to enroll yourself or your dependents in a group medical plan through the School Board of Broward County, Florida, provided that you request enrollment within thirty (30) days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement or adoption. In the case of COBRA continuation coverage, you may be eligible for a special enrollment period if the COBRA coverage is exhausted. A special enrollment period is not available if coverage under your prior plan or COBRA coverage was terminated for cause or as a result of failure to pay any required contributions toward the cost of coverage on a timely basis.

_____ _____

Employee's Signature Date

_____ _____

Print Name Personnel Number

Signed before me on this _____ day of _____, _____.

_____

My Commission Expires: