

**BOARD OF COOPERATIVE EDUCATIONAL SERVICES
SOLE SUPERVISORY DISTRICT OF ONEIDA, HERKIMER AND MADISON
COUNTIES
PO BOX 70
NEW HARTFORD, NY 13413**

HEALTH INSURANCE DECLINATION FORM

I do not wish to enroll in the Oneida County BOCES Health/Dental Plan at this time.

I understand that by declining to enroll at this time:

- I may subject myself and my eligible dependents to certain applicable waiting periods if I decide to enroll at a later date.
- I may be forfeiting the right to such coverage after my retirement.
- I will need a statement of physical condition when I enroll.

Name _____

Signature _____

Date _____