Retiree - Health Insurance Waiver Form
2024 Calendar Year
(January – December 2024)

___ I elect to waive health insurance

I elect to waive retiree medical coverage for myself and my dependent(s) offered by Rock County. I understand that by declining medical coverage, I will not have the opportunity to enroll myself or my dependent(s) on Rock County's health insurance plan after this 60 day election window.

Employee Name (printed): _____ Date: _____

Employee Signature: _____