



INSURANCE WAIVER

Vermilion Local School District

HOSPITALIZATION INSURANCE WAIVER

This certifies that I do NOT want Health Insurance
as provided by Vermilion Local School District

Full Name (printed): _____

Signature: _____ Date: _____

DENTAL INSURANCE WAIVER

This certifies that I do NOT want Dental Insurance
as provided by Vermilion Local School District

Full Name (printed): _____

Signature: _____ Date: _____

VISION INSURANCE WAIVER

This certifies that I do NOT want Vision Insurance
as provided by Vermilion Local School District

Full Name (printed): _____

Signature: _____ Date: _____