Mamaroneck UFSD

HEALTHCARE BUYOUT FORM
PERIOD OF COVERAGE 1/1/2019 THROUGH 12/31/2019

Name (Print) _____

Employee's ID#_____

Healthcare Buyout

I hereby confirm that I have and will continue to have health insurance through December 31, 2019 with _____(provider) and decline health insurance provided by Mamaroneck Union Free School District (the District). I elect to receive the annual twelve-hundred dollar ($1200) buyout, paid through payroll in two equal installments in June and December 2019. I also confirm that should I become uninsured for any reason, I will notify the District immediately.

_____ _____
Signature Date

Submissions:
To take the buyout you must have alternate health insurance coverage.
Please make a copy of your Health Insurance ID card and attach it to this form.

This completed form and proof of insurance must be submitted electronically to fcasterella@mamkschools.org.

The Healthcare Buyout form must be completed and submitted electronically each year. Proof of health insurance must be submitted electronically each year.

Please note that this form covers January 1, 2019 through December 31, 2019.

Retirement and Buyout:
Please note that if you are planning to retire in June 2019, your buy-out payment will be reduced by 50% or $600.00.

If you plan to retire in June 2019 and would like to have health insurance into retirement, you must enroll into the health plan effective January 2019.