Health/Dental Benefits
Opt-Out Election Form
July 1, 2020 - June 30, 2021

BRRSD Employee Name: _____ Location: _____

The Bridgewater-Raritan Board of Education is offering benefits "Opt-Out" compensation to eligible employees who choose to waive the Board's health insurance coverages. Under this provision, an employee may elect to waive medical, prescription and dental benefits in return for a waiver incentive. Employees who elect to waive all or some of their coverage options shall receive an incentive which reflects 25% of the Board's savings, not to exceed $5,000. Acceptance of this waiver involves important factors that should be considered:

1. If elected, the benefit waiver for all employees will be paid in 20 equal installments (September through June).
2. The payment will be treated as taxable income.
3. Once waived, you will be ineligible to receive benefits until open enrollment for the following contract year ***unless*** you experience a qualifying life event (loss of job, loss of benefits, divorce, etc.). ***It is the employee's responsibility to notify the Human Resources Department if benefits are lost for any reason and to complete an enrollment application.***
4. You can elect to waive medical insurance alone and enroll in dental insurance and/or prescription coverage. However, if you do elect prescription coverage, you will be required to pay the greater of 1.5% of your annual salary or a percentage of the premium based on the State Chapter 78 contribution chart. You will not be charged a premium if you elect to enroll in the dental plan.

I elect to waive the following insurance coverage being offered by the Bridgewater-Raritan Board of Education for myself (and my dependents), effective July 1, 2020 through June 30, 2021 (check all that apply):

☐ Medical ☐ Prescription ☐ Dental*

Note: The waiver of dental insurance does not include payment of a waiver incentive.

Level of coverage waived (check one):

Single ☐ Parent/Child ☐ Member/Spouse ☐ Family ☐

I certify that all of my dependents and I have health benefits coverage under:

Name: _____ Relationship: _____ Health Plan: _____

I have read, understood, and agree to the provisions outlined above.

Employee Signature: _____ Date: _____

Return this form to the Human Resources Department by 6/1/2020
Proof of coverage (Photocopy of health benefits ID card) must be attached.