



Cash In Lieu of Medical Benefits (FOR BENEFIT ELIGIBLE EMPLOYEES ONLY)

If you are eligible to receive Cash In Lieu of Medical benefits, you have the opportunity to decline medical insurance through San Mateo Foster City School District's group health plan and receive a monthly cash in lieu of medical insurance.

To be eligible, you must provide written proof of satisfactory medical insurance.

To be eligible to enroll in the Cash In-Lieu of Medical Benefits categories below must be met:

1. **Obtain and provide a copy proof (front and back) of other current health care coverage. The required proof is an official document verifying you are insured under a group health insurance plan.**
2. **Submit proof to Payroll/Benefit Department along with a signed Election of Cash In-Lieu form.**
3. **MUST BE RENEWED ANNUALLY.**

Both the application and proof of other group health plan coverage must be received and approved by Payroll/Benefits Department. Upon approval, cash payment in lieu of medical insurance will be scheduled for the next available pay check date. If you later wish to enroll in San Mateo Foster City School District health coverage, except for death of or divorce from the individual covering you under their plan, you will be subject to the normal open enrollment and plan waiting periods.

The benefit is paid each pay period and as a taxable benefit, it is subject to FICA, Medicare, Federal, and State tax.

The amount deducted for taxes depends on individual circumstances as determined by state and federal taxing authorities. We regret that we are unable to provide individual calculations prior to the actual payment.

ITEMS TO CONSIDER BEFORE DECLINING MEDICAL COVERAGE

Once you apply and receive cash in-lieu of medical benefits, you may only enroll in the district health plan if a qualifying Section 125 event occurs:

Qualifying Events Are:

1. **MARITAL STATUS CHANGE:**
 - Marriage
 - Death of spouse
 - Divorce or annulment
 - Legal separation
2. **NUMBER OF DEPENDENTS CHANGE:**
 - Birth
 - Adoption or placement for adoption
 - Death of dependent child
 - Newly eligible dependents due to plan design change

Note: HIPAA allows the employee who may have elected employee only coverage initially to not only add a new dependent, but also allows the employee to add the spouse at the time the new dependent is added. HIPAA does not require that all eligible dependents (i.e., other dependent children) be added.
3. **LOSS OF COVERAGE:**
 - If the employee loses other coverage (e.g. spouse's health plan coverage terminates, or Medicare or Medicaid eligibility ends)

Please complete the enclosed "Election of Cash In-Lieu of Participation in Group Medical Insurance" form if you decide to decline medical insurance, and return it to Payroll in the Business Office by December 15. For New Hires, election form is due by the 15th day of the month to become effective the 1st day of the following month.



Election of Cash In-Lieu of Participation in Group Medical Insurance
(FOR BENEFIT ELIGIBLE EMPLOYEES ONLY)

Name (please print)	Last 4 Social Security Number
Department or School Site	Home or Cell Phone #

I certify that I am covered by another health plan and have attached verification (front and back copy) of my coverage offered through:

Parent OR Spouse's Name: _____

Parent OR Spouse's Employer: _____

Medical Plan: _____

(INITIAL EACH LINE)

_____ I understand that, by exercising the election to receive monthly payments, I will receive no benefits or coverage from San Mateo Foster City School District (SMFCSD) medical plan. If I wish to enroll in any of SMFCSD group medical plans at a later date, I will be subject to that plan's enrollment rules.

_____ I understand that under the cash in-lieu benefit election, I must submit the form by the 15th of the month to become effective the 1st of the following month. Also, I understand that SMFCSD will not back pay my cash back and the benefit becomes effective moving forward.

_____ I understand that my eligibility for cash in-lieu is subject to an annual recertification process. Annual renewal is due every 15th of December to become effective the following month.

_____ I understand that if I DO NOT submit the annual recertification form, any leftover cash in lieu used toward benefits will be deleted. I will be responsible for the difference and the District will not back pay.

_____ I understand that I must notify Payroll/Benefits within 30 days of a discontinuation, cancellation, or any other similar change in medical coverage.

Signature	Date
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