

LAKEVIEW SCHOOL DISTRICT WAIVER OF MEDICAL PLAN COVERAGE ELECTION FORM - EMPLOYEE

You have the opportunity to participate in the Waiver of Medical Plan Coverage under the Lakeview School District Healthcare Waiver Plan (the "Plan") and elect to receive additional taxable compensation in lieu of employer Medical Coverage. Complete Section 1, sign at the bottom, and return this Election Form to the Business Office. Your compensation will be increased in the amount as set forth in Section 2. Only those Employees who meet the Plan's eligibility requirements, as described in the Healthcare Waiver Plan, may participate in the Plan.

Irrevocable Election If you choose to participate in The Plan, you cannot change or revoke your election until the next open enrollment period for the next Plan Year that runs from January 1st through December 31st; unless, you have a change of election event as described in the Healthcare Waiver Plan. The election change must be requested within 30 days of the event, and must be on account of and consistent with the change in election event as defined in the Plan.

1. Employee Information

Name: _____ SS#: _____

2. Waiver Compensation

By waiving participation in the Medical Plan, I understand that my increased compensation during the Plan Year will be paid in the amount agreed to and determined by the employer. This amount will be calculated on a pro-rated basis when waiver compensation is elected or eligibility ceases, and the period of participation is less than 12 months.

3. Employee Statement and Signature

I hereby elect to participate in the Waiver of Medical Coverage under the Lakeview School District Healthcare Waiver Plan for the duration of the Plan Year. I certify and have provided documentation to verify that I am covered under another group health plan. I acknowledge that I have read and understand any material (including the Healthcare Waiver Plan) concerning the effect of my election. I further understand that by this election, I agree to hold Lakeview School District harmless from any medical claim expenses incurred subject to group/individual Medical Plan coverage on my eligible dependents or myself. My election on this Election Form revokes any prior election relating to the same matter under the Plan. Before the beginning of each Plan Year (the Open Enrollment Period), I will be offered the opportunity to change my election for the upcoming Plan Year. I also understand that if I fail to make a change of election by the end of the Open Enrollment Period, my current election will automatically apply to the upcoming Plan Year.

This Election Form is subject to the terms of the Plan as in effect from time to time and shall be governed by and construed in accordance with the laws of the State of Pennsylvania to the extent not superseded by Federal law.

Employee's Signature

Date

Administrator Use Only:

Proof of other coverage received: _____

Date: _____

Received by: _____