HEALTH INSURANCE OPTION FORM

To the Superintendent:

I, _____, certify that I have read the procedures relating to the Health Insurance Buy-out Option.

I have indicated below the option that I am electing for the _____ school year.

- ☐ I am currently enrolled in the family health insurance coverage and elect to have no coverage. I herewith submit proof of alternative health insurance coverage and the executed waiver below.

- ☐ I am currently enrolled in the supplemental health insurance coverage and I elect to have no coverage. I herewith submit proof of alternative health insurance coverage and the executed waiver below.

- ☐ I am currently enrolled in the individual health insurance coverage and elect to have no coverage. I wherewith submit proof of alternative health insurance coverage and the executed waiver below.

- ☐ I currently do not have health insurance coverage with the District, but previously had a level of coverage and I wish to continue with my election of no insurance. I herewith submit proof of alternative health insurance coverage and the executed waiver below.

- ☐ I am a new employee. I would be eligible for the supplemental level of insurance, and I wish to have no insurance coverage and the executed waiver below.

_____ _____

Signature Date

DECLINATION OF MEDICAL INSURANCE AND WAIVER OF LIABILITY

I, _____, swear that I have been advised of the availability of medical benefits available. I chose to elect no insurance and agree to pay for all uninsured medical costs. I further agree that the District shall not be liable for any uninsured medical costs.