South River Board of Education

Waiver of Health Benefits

Employee's Name:_____
(printed)

I hereby certify that I am waiving my health benefits coverage under: (check appropriate level and coverage):

_____ Single _____ Two Adults _____ the District's Medical/Rx Benefit Plan
_____ Family _____ Parent+Child(ren) _____ the District's Dental Coverage

In return, the Board has agreed to reimburse me at the stated contractual amount, payable on or about June 15th of the current year and subject to all appropriate deductions. This payment is not to be considered a salary payment and, as such, is not pensionable. I understand that I am responsible for any additional tax liabilities on this money.

I further certify that I understand and agree that my waiver of the foregoing benefits is of my own volition. It is not based upon any representations by either the South River Board of Education or any union representation other than the aforementioned monetary reimbursement. I agree to hold both the Board and the Association harmless with regard to any adverse results of my voluntary and informed waiver of the foregoing benefit.

I understand that I may revoke this waiver prior to the expiration date shown above only under the following hardship circumstances: (re-enrollment as of the 1st of the month following notification to the Business Office of the hardship/change of life circumstance)

- Termination of employment of person with benefits (proof of termination of benefits required)
- Legal Separation (copy of decree required)
- Group contract/policy terminated of person with benefits (proof of termination required)
- Divorce (copy of decree is required)
- Death of Spouse (copy of death certificate required)
- Military Discharge (copy of DD214 required)

Should I revoke the foregoing waiver, I understand that the reimbursement to which I am entitled shall be pro-rated based upon the period of time I am not covered by the district's benefit plan(s).

I further understand that I may restore the benefits for which I am eligible during the next open enrollment period. Such benefits would commence on July 1st of the next academic year. Should an employee die prior to receipt of payment for opting out, the appropriate pro-rated amount shall be paid to his/her estate pursuant to the contract provision.

The required proof of other coverage that must be included with this form are as follows:

1. A letter on letterhead from the company in which you are enrolled stating that your coverage is active (see sample).

Signed:_____
(Employee)

Date:_____

Business Administrator verification of
Other health benefit coverage:
Company:_____
BA Signature:_____