ELIZABETH FORWARD SCHOOL DISTRICT

401 Rock Run Road, Elizabeth, PA 15037-2416 · 412-896-2304 · FAX: 412-751-9483 · www.efsd.net

ANNUAL DECLINATION OF MEDICAL INSURANCE COVERAGE APPLICATION FOR PAYMENT IN LIEU OF COVERAGE & GENERAL RELEASE (Health Insurance Buyout Form)

This form must be completed annually and submitted to the Business Office.

I hereby decline to participate in the medical insurance coverage available to me by the School District.

I hereby apply for the $3,500.00, or other amount as defined in a pertinent collective bargaining agreement or employment contract, per semester for Non-participation or Dual Coverage payment in lieu of District sponsored health care coverage. **I have attached a photocopy of valid medical insurance cards to this form as evidence of medical insurance and in order to receive the payment following application of appropriate withholding taxes, mandatory contributions, etc.**

I HEREBY GENERALLY AND FULLY RELEASE THE ELIZABETH FORWARD SCHOOL DISTRICT FROM ANY AND ALL LIABILITY FOR UNPAID MEDICAL BILLS AND ALL OTHER CLAIMS WHICH MAY ARISE OR BE INCCURRED BY ME OR A MEMBER OF MY FAMILY.

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Employee Name

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Employee Signature

Date

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