Frankfort-Schuyler Central School District and the
Frankfort-Schuyler Teachers' Association
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.

Waiver of Group Coverage

Company Name:_____ _____

Employee Name: _____ _____ Date of Birth: _____

I understand that I am eligible to participate in my employer's group health insurance coverage:

Please Check All That Apply:
[ ] I waive my employer's group **health** insurance coverage for myself and my dependents

Reason for Waiving Coverage - Please Check One :
[ ] Covered through spouse's employer [ ] Covered through a parent's employer
[ ] Under 65 Retiree covered by previous employer's insurance program
[ ] Other Please specify: _____ _____

Please Read and Sign Below:
This plan meets requirements of Affordability and Minimum Value. In waiving coverage, I understand that I and/or my dependents may enroll under this plan in the future only as the result of certain qualifying conditions. For example,
- Within 30 days of involuntarily loss of other group coverage
- At the time of my employer's open enrollment.

Signature: The undersigned certifies that, to the best of my knowledge and belief and under penalty of perjury, the information listed above is true and complete.

Employee Signature: _____ Date: _____