South River Board of Education

Waiver of Health Benefits

As of July 1, 2019, all employees will have the choice to waive health and dental insurance coverage. The benefit amount is 25% of the annual premium or $5,000, whichever is less. Each school year, employees may choose to "opt out" of insurance benefits. Employees choosing to "opt-out" will be required to provide proof showing that their dependents are covered under another health benefit program. Employees who are eligible for benefits may re-enroll upon proof of a qualifying event. Employees who are not employed during the full year (July 1 – June 30) and choose the waiver shall have their payments prorated accordingly. This applies to new hires after September 1 and any employment termination that is effective prior to June 30. Employees who choose the waiver and are on unpaid leave of absence without medical benefits shall have their payments prorated as well.

_____

_____ I do wish to participate in the waiver program by waiving the following coverage(s).

_____ Health benefits only _____Single _____Family/Employee/Spouse/ Parent+Child(ren)

_____ Dental benefits only _____Single _____Family/Employee/Spouse/Parent+Child(ren)

I hereby waive the above indicated coverage for the period of July 1, 2025 through June 30, 2026. I also recognize the following criteria for re-entry to the insurance program:

1. Employees and their family members have the option to waive or re-enter the health insurance programs by completing an enrollment application during the annual open enrollment period.
2. The decision to waive coverage cannot change until the next annual open enrollment period. Since most employees electing to waive coverage will be doing so because they have coverage through their spouse, a "hardship provision" for re-entry is available. This provision allows employees and family members to re -enter the program, on an immediate basis, without the necessity of health questionnaires. The provision allows for re-entry only in the following situations which result in the loss of coverage through a spouse:
   - Death (copy of certificate required)
   - Group Contact/Policy Terminated
   - Military Discharge (Form DD214 required)
   - Termination of Employment
   - Divorce (copy of Decree required)
   - Legal separation (copy of Decree required)

   Please Note: To be eligible for the waiver election, you must provide proof of medical coverage, such as a copy of a current medical insurance identification card to the board office with this form or a letter from the carrier or employer.

Employee Signature: _____Date:_____

Print Employee Name: _____

Business Administrator Signature: _____ Date: _____

Other Health Insurance Company: _____

FOR BOARD USE ONLY

DATE OF HIRE_____ PLAN ELIGIBILITY_____