The Somerset Hills School District
Insurance Waiver Form

Employees may elect to waive medical and/or dental coverage through the District on an annual basis by submitting a completed waiver form. Participation in the program shall be subject to the following conditions:

a) Employees must provide proof of insurance coverage under an alternate medical and/or dental plan. Please provide a front and back copy of your medical and dental cards as applicable.

b) The waiver form must be submitted to the Business Office on an annual basis and will be effective for the entire year (July 1 – June 30).

c) An employee who has waived coverage, but later loses coverage in her/his alternate insurance plan may enroll under the Board of Education's plan subject to the rules and regulations of the insurance carrier. In such cases of emergency re-entry, proof of loss of your other insurance coverage must be provided.

d) Employees may re-enroll into the district's benefit plan during the open enrollment period or as a result of some other type of qualifying event*. Employees who waive district coverage and subsequently wish to re-enroll into the districts health or dental plan must submit a completed enrollment application to the districts Benefits Manager within thirty (30) days from the termination date of the alternate health insurance plan. Proof of the qualifying event must be provided if enrollment is outside the open enrollment period.

* Examples of qualifying events: Exhaustion of COBRA coverage; Termination of employment or coverage eligibility under the spouse's health plan; Loss of coverage eligibility in spouse's plan due to a reduction in the spouse's work hours; Divorce or legal separation; Death of the employee's spouse; Termination of the employer's contribution toward coverage of the spouse's plan; Termination of the spouse's plan Coverage.

Please complete and return to the Business Office.

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Insurance Waiver Form

Please choose *either* the Family or Single waiver. Do not check both. If you are single with no dependent children, you check Single. Any other type of coverage is considered Family.

_____ I wish to waive my full **Family** (Family, Husband/Wife, Parent/Child) health insurance coverage for the period July 1, 2023 – June 30, 2024 and confirm that I have alternate health and/or dental coverage for each plan that a waiver is sought, as indicated below:

Check the appropriate plan(s):
___ Health Insurance Coverage
___ Dental Insurance Coverage

____ I wish to waive my **Single** health insurance coverage for the period July 1, 2023 – June 30, 2024, and confirm that I have alternate health and/or dental coverage for each plan that a waiver is sought, as indicated below:

Check the appropriate plan(s):
___ Health Insurance Coverage
___ Dental Insurance Coverage

Please provide the name and policy numbers of all alternate health insurance plan(s) and/or attach proof of your other coverage: ______________________

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Print Employee Name ____
Signature ____
Date_________________________