# OPTIONAL HEALTH CARE OPT-OUT

## 01/01/2027 to 12/31/2027

The Southgate Board of Education and selected employee bargaining groups have agreed to provide an incentive to eligible members who elect to waive their health care benefits. Those specific benefits are medical, and/or dental and vision. In consideration of your election, the Board of Education will provide an annual cash in lieu payment of $4,000 for medical and/or $200 for dental and vision. This cash in lieu payment will be paid in December 2027.

The following are the set of conditions of this mutual understanding:

1. The term of this waiver shall be the period of January 1, 2027 through December 31, 2027. (**An employee must renew their election <u>each year</u> by submitting a signed copy of the Alternative Health Care Coverage Affidavit.**)

2. This election is available only to those who are full-time employees if provided in the employee's collective bargaining groups or in the employee's individual employment contract.

3. The employee's election period shall be during the month of November. Members becoming eligible for benefits during different times of the year shall be granted 30 days from the date of eligibility to make their election. Those employees will be granted a prorated amount.

4. The election becomes irrevocable to the employees with exception of the conditions mentioned in Item 5.

5. If an employee incurs a change in family status such as marriage, divorce, legal separation, birth or adoption of a child, death of a spouse or child, termination or commencement or other change of a spouse's employment, a transfer to or from covered employment by a participant or the spouse, a participant or a spouse taking an unpaid leave of absence, or a significant change in the health coverage or the cost of coverage of the participant or spouse attributable to the spouse's employment, and other events permitted by regulations or rulings issued by the Internal Revenue Service, an employee will be allowed to alter his/her benefit election. In these instances, the employee shall be entitled to a proration of the incentive payment for the period of time that the employee made the election through the date of revocation.

6. The electing employee must agree to sign an affidavit that stipulates current coverage from an alternative plan for the employee, and all covered dependents, that is provided by an employer, or through a plan administered outside the Southgate Community School District.

7. The cash payment cannot be sheltered in any form from Federal and State income taxes.

# ALTERNATIVE HEALTH CARE COVERAGE AFFIDAVIT
## Southgate Community School District - 2027

Employee Name: _____
(Please print)

This affidavit form must be completed by any eligible staff member who is exercising his/her option to waive entitlement to benefits for **January 1, 2027 through December 31, 2027**, by checking the selected box(es) below.

| | | **Annual Monetary Value** |
|---|---|---|
| ☐ | Medical | $4,000.00 |
| ☐ | Dental and Vision | $ 200.00 |

The Affordable Care Act (ACA) states that all persons must have healthcare coverage. Southgate Community School District is an Applicable Large Employer (ALE). If you were/are enrolled or attempted to enroll in the Market Place, any tax credits you are eligible for are now void because you are *ELIGIBLE* for coverage here – whether you enroll or not in Southgate's healthcare coverage. Southgate files all required forms with the IRS informing them that you were *offered* healthcare coverage and declined because you were insured elsewhere.

I certify that I am opting out of medical and/or dental/vision coverage offered to me through Southgate Community School District because of the following reason:

Check one:

☐ My spouse also works for Southgate Community Schools and I have coverage through him/her.

Name of Spouse: _____

☐ I have coverage through my spouse's employer.

Name of Spouse: _____

Name of Spouse's employer where coverage is held: _____

Carrier (BCBS, Aetna, etc.) and Group Number: _____

☐ I have coverage through my parent(s):

Name of Parent(s): _____

Name of Parent's employer where coverage is held: _____

Carrier (BCBS, Aetna, etc.) and Group Number: _____

☐ I have coverage through another source (COBRA, Medicaid, Medicare, Military, etc.):

Name of source: _____

Carrier (BCBS, Aetna, etc.) and Group Number: _____

☐ I am also waiving coverage for the following dependents:

| Dependent Name | Date of Birth | Last Four of SSN |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

_____ _____
Employee Signature Date

**Return this form, via email, to Jodi Badder (badderj@sgate.k12.mi.us)**