MONTGOMERY TOWNSHIP SCHOOLS
INSURANCE WAIVER FORM

Employees may elect to waive medical and/or dental coverage on an annual basis and receive a monetary sum in lieu of benefit coverage 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 to be eligible for the waiver program.

b) The waiver form must be submitted to the Human Resources office and must be effective for the entire year (July 1 – June 30). Each waiver will be effective for one (1) year and must be renewed each year if a continued waiver is desired.

c) An employee who has waived coverage, but later loses coverage in her/his alternate insurance plan, may resume coverage under the Board of Education's plan subject to the rules and regulations of the insurance carrier. In such cases of emergency re-entry, the reimbursement amount shall be prorated on a monthly basis.

d) One-half of the annual reimbursement amount shall be issued to participating employees on the first pay period in January for the July 1 – December 31 period, and the remaining one-half shall be issued on the first pay period in June for the January 1 – June 30 period.

e) Employees waiving full family insurance coverage shall receive an annual reimbursement of $3,100.00 – Health / $400.00 – Dental.

f) Employees waiving single insurance coverage shall receive an annual reimbursement of $1,850.00 – Health / $150.00 – Dental.

g) 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 district's health or dental plan must submit a completed application to the district's Benefits Manager within thirty (30) days from the termination date of the alternate health insurance plan. Coverage under the district's health plan will become effective no later than the first day of the month after the carrier receives the completed application from the employee.

* 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 reverse side and return to the Business Office.

(Over)

MONTGOMERY TOWNSHIP SCHOOLS
INSURANCE WAIVER FORM

_____ I wish to waive my full **Family (Family, Husband/Wife, Parent/Child)** health insurance coverage for the period July 1, 2018 – June 30, 2019, 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 - $3,100.00 per year

___ Dental Insurance Coverage - $400.00 per year

____ I wish to waive my **Single** health insurance coverage for the period July 1, 2018 – June 30, 2019, 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 - $1,850.00 per year

___ Dental Insurance Coverage - $150.00 per year

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

_____

_____

_____

Print Employee Name _____

Signature _____

Date_____

A completed form must be submitted to the Business Office by May 31st.

Revised 3/22/18