PARSIPPANY-TROY HILLS TOWNSHIP SCHOOLS

Business Office

WAIVER OF HEALTH BENEFITS COVERAGE

Policyholder Name: Parsippany-Troy Hills Board of Education

Employee Name: _____ SS# _____

Job Title: _____ Location: _____

Date of Hire: _____ Date of Birth: _____

I was given the opportunity to enroll myself and my dependent(s) in group health benefits offered by my employer. I hereby elect to waive the following coverage for the **2019/2020 school year**:

_____Self _____Dependents only (if eligible) _____Both

Type of Coverage I am entitled to: ☐ Single ☐ Family ☐ Parent/Child ☐ Two Adults

I understand that if I waive all health benefit coverage, I will not be required to make a contribution for same, but if I re-enroll at a later date, I will be required to contribute.

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To be eligible for a waiver payment you must:

- Waive ***ALL*** benefits (Medical, RX, Dental & Vision) whether for yourself, spouse or your dependents.
- Submit this form ***signed*** and ***witnessed***, upon being hired, during an open enrollment or within 30 days of qualifying event to Stella Gizas in the BOE.
- Provide required **dated written proof from the employer of active insurance coverage under an alternate medical plan**. (Photocopy of insurance card is not sufficient).

Employees may re-enroll in the plan during the open enrollment period or within 30 days of a qualifying life event*. Employees who waive district coverage and subsequently wish to re-enroll must submit a completed Enrollment Application Form to Human Resources. *Waiver form will become effective upon receipt of all documentation and will remain in effect for one year, unless there is a qualifying life event. Renewal of waiver must be done annually during open enrollment.*

*Examples of qualifying event:

Exhaustion of COBRA coverage through another employer | termination of employment or dependent plan coverage or coverage eligibility under spouses health plan | loss of coverage eligibility in spouse's health plan due to a reduction in the spouse's work hours or termination of spouse's plan coverage | death of the employee's spouse or dependent | Employee or spouse becomes entitled for Medicare | change in family status that results in increase or decrease in number of eligible family members; for example: Marriage, divorce, legal separation or annulment, Birth, adoption, acquiring foster child or stepchild, issuance of court order requiring employee to provide coverage for child, dependent ages out | Exhaustion of FMLA whereby an employee enrolls in spouses' coverage.

I understand that I will receive a waiver payment according to the terms of my existing contract or recently expired contract in lieu of benefits as follows: one half of the annual payment shall be issued to participating employees in the first pay period of January for the July 1-December 31 period and the remaining one half shall be issued in the first pay period of June for the January 1-June 30 period.

_____ _____

Signature of Employee Date

_____ _____

Signature of Witness Date

Business Office Use

_____ _____

Approved Date Effective Date