Mansfield Township Board of Education
Waiver of Benefits
July 1, 2026 - June 30, 2027

Employee name (printed) _____

I hereby certify that I am waiving my health benefits coverage under (check appropriate level & coverage type)

☐ Single ☐ Two Adult ☐ Family ☐ Parent/Child(ren)
Check one above

☐ Medical/Prescription ☐ Dental
Check applicable above

NEW EMPLOYEES - Please submit proof of dependent(s) with this form.
For a spouse/partner:
* marriage certificate or NJ domestic certificate of domestic partnership dated prior to 02/19/07
* front page of Form 1040 from last year that includes your spouse/partner

For a Natural or Adopted Child: child's birth certificate listing you as parent
For Step Child: child's birth certificate listing employee's spouse as parent
For Legal Guardian, Grandchild, Foster Child: final court orders with judge's signature and seal

You can waive one or both of the above benefits. If you waive medical/prescription coverage but remain in dental you will be required to pay either 1.5% of your salary or the Chapter 78 percentage of premium, whichever is greater. The contribution cannot exceed the actual premium cost of the benefit. The waiver incentive for medical/prescription is 25% or $5,000, whichever is less. The waiver incentive for dental is 50% of the cost saved by the board.

I further certify that I understand and agree that my waiver of the foregoing benefits is of my own volition. It is not based upon representation from either the Mansfield Township Board of Education or the Mansfield Township Education Association. I agree to hold both the Mansfield Township Board of Education and the Union harmless with regard to any adverse results of my voluntary and informed waiver of the foregoing benefits.

I understand that I may revoke this waiver prior to the expiration date shown above only under the following hardship/change of life circumstances:

* Termination of employment of person with benefits (proof of termination required)
* Legal Separation (copy of decree required)
* Group contract/policy terminated of person with benefits (proof of termination required)
* Divorce (copy of divorce decree required)
* Death of spouse (copy of death certificate required)

I further understand that I may restore the benefits for which I am eligible during the next Open Enrollment period which is in May for changes effective July 1.

Signed: _____ Date: _____

The completed waiver form **must be submitted with proof of current insurance benefits**. Proof of insurance can be a letter on company letterhead from the company or entity carrying your health benefits. This letter must have a current date and state that you are a covered individual under a specific medical/prescription plan(s) and/or dental plan. Or, you may obtain a Certificate of Creditable Coverage directly from your insurance carrier (ie: Aetna, BCBS, etc) with a current date listed on it.

☐ **I have submitted proof of current insurance benefits with the waiver.**