MAPLE SHADE BOARD OF EDUCATION
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WAIVER OF HEALTH BENEFITS COVERAGE FORM

For **2020/2021** School Year, I am waiving the following coverage: ❑ **Medical *** ❑ **Prescription *** ❑ **Dental ***

❑ **ATTACHED is proof that I am covered under another medical plan * ***

❑ **LISTED below are the names and birth dates of my eligible dependents * ***

Self: _____ D/O/B: _____

Spouse: _____ D/O/B: _____

Dependent #1: _____ D/O/B: _____

Dependent #2: _____ D/O/B: _____

Dependent #3: _____ D/O/B: _____

Dependent #4: _____ D/O/B: _____

Dependent #5: _____ D/O/B: _____

Dependent #6: _____ D/O/B: _____

Dependent #7: _____ D/O/B: _____

I understand the following:

1) I may not re-enroll in benefits coverage until the next open enrollment period, except in certain circumstances subject to carrier determination.
2) This waiver reimbursement is subject to all applicable taxes.
3) I agree to hold both the Board and the Association (if applicable) harmless with regard to any adverse results of my voluntary and informed waiver of the foregoing benefits.
4) Employees must meet benefits eligibility criteria to be eligible for waiver of health benefits. (Contracted minimum work week of 30 hours)
5) Chapter 2 P.L. 2010 (eff. May 21, 2010) changed the following guidelines:

* 5a) Medical waiver payments are limited to the lesser of: 25% of the SAVED cost or $2,500 (annually).
Prescription and dental waiver payments are limited to the lesser of: 50% of the SAVED cost or $2,500 (annually).
The SAVED cost is the premium total of medical PLUS prescription and dental reduced by the calculated employee contribution (greater of: 1.5% of Salary or Phase-In Table Calculation).
The $2,500 cap is all-inclusive of medical, prescription and dental.

* 5b) Must waive BOTH medical and prescription to be eligible for waiver payment.

* 5c) Must waive BOTH medical and prescription to avoid paying health deduction.

6) This waiver reimbursement will be made to those individuals electing to waive benefits coverage during open enrollment only. If an employee elects to terminate their health benefits coverage during the year, other than open enrollment time, they shall not be eligible for the waiver payment, however they can still elect to terminate their health benefits coverage.
7) I understand that if for any reason, my dependent status changes, I will notify Payroll/Superintendent's Office immediately. I will be responsible for returning any waiver reimbursement that I received in error.

*** * IMPORTANT - Employee: Please read the following before signing.**
By signing, I attest I have provided a copy of my current medical insurance card and, if applicable, a list of my eligible dependents.
If I fail to provide the requested information, my waiver request will not be processed.

EMPLOYEE NAME (Print Legibly): _____

EMPLOYEE SIGNATURE: _____ DATE: _____

ASSOCIATION SIGNATURE: _____ DATE: _____

BOARD OF ED. SIGNATURE: _____ DATE: _____

PLEASE RETURN COMPLETED FORM TO THE PAYROLL OFFICE