Northern Burlington County Regional School District
Waiver of Health Benefits
July 1, 2024 – June 30, 2025

Employee name (printed) _____
I hereby certify that I am waiving my medical/prescription and or dental coverage under: (check appropriate level & coverage)

Single: _____, Two Adult: _____, Family: _____, Parent/Child: _____
Medical: _____, Prescription: _____, Dental: _____

By providing proof (copy of other insurance ID cards) of my other coverage I will receive a dollar incentive. The dollar incentive for waiving medical, prescription, and or dental coverage is 25% or $5,000, whichever is less, of the saved cost of the coverage being waived. The incentive is paid on June 30th of each school year. Incentive checks are subject to all appropriate tax deductions.

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 Northern Burlington County Regional School District or the Northern Burlington County Regional Education Association. I agree to hold both Northern Burlington County Regional School District 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**
- **Legal Separation (copy of decree required)**
- **Group contract/policy terminated of person with benefits (proof of termination required)**
- **Disability of spouse which eliminates benefits (proof of termination of benefits required)**
- **Divorce (copy of divorce decree is 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. Such benefits would commence on July 1st of the next renewal year.

Signed: _____
(Employee)

Date: _____

Witness: _____
(Business Administrator)

Date: _____

Two original copies of this waiver shall be signed along with a copy of the other insurance card. The employee shall keep one and one shall be placed in the employee's personal file.