# Pompton Lakes Board of Education
# Waiver of Medical, Prescription, Dental, or Vision Benefits
# July 1, 2025—June 30, 2026

**Employee name (printed) _____**

**I hereby certify that I am waiving my medical, prescription, dental, or vision coverage:** ***Employees will not receive a waiver dollar incentive under this provision for waiver of medical only, prescription only, dental only, or vision only or any combination of these benefits (other than medical/prescription). The medical and prescription must both be waived in order to receive the dollar incentive.***

**Check coverage you are waiving: Medical_____ Prescription_____ Dental_____ Vision_____ All Benefits_____**

***I understand that I am not charged a payroll contribution toward the cost of the dental and vision benefits for myself and my eligible dependents. It is non-contributory on my part but I still wish to waive and not be enrolled. However, as long as I waive the medical and prescription I can receive the dollar incentive of $2,000, if eligible.***

***I understand if I wish to enroll in dental and/or vision I will need to complete an enrollment application.***

***By providing proof (copy of other insurance ID cards) of my other medical and prescription coverage I will receive a dollar incentive of $2,000, if eligible. This proof of coverage must be provided for each year that I waive coverage. I understand and agree that if I have not been employed during the full school year (July 1 to June 30), or if I am on any leave of absence without medical benefits, any payment due to me under this waiver will be accordingly prorated.***

**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 Pompton Lakes Board of Education or the Pompton Lakes Education Association. I agree to hold both Pompton Lakes 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**
- **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.**

**Signature of Applicant: _____Date: _____**

**Signature of Certifying Officer: _____Date: _____**