

# 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 **2021/2022 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 **current 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 Stella Gizas, BOE. 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

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### Business Office Use

\_\_\_\_\_  
Approved

\_\_\_\_\_  
Date

\_\_\_\_\_  
Effective Date