# MEDICAL GROUP INSURANCE WAIVER FORM
# JEFFERSON TOWNSHIP BOARD OF EDUCATION

**Medical Benefits Waiver**

I waive my right to participate in the Medical Plan offered by Jefferson Township BOE for which I am eligible for the period* January 1, 2022 and ending December 31, 2022.

**Please check one of the options Below:**

| | | | | | |
|---|---|---|---|---|---|
| Single | $1,750 Annually* | ☐ | 2 Adults | $3,500 Annually* | ☐ |
| Parent Child(ren) | $3,000 Annually* | ☐ | Family | $4,500 Annually* | ☐ |
| Non-Cash Waiver *(for employees with alternate coverage in the SHBP or SEHBP)* | | ☐ | | | |

Applicant must provide copy of currently active insurance card as proof of other coverage:

Insured's Name: _____ Policy # _____

Insurance Company Name: _____

***Prorated for New Hires and for employees who waive coverage as a result of a qualifying life event.**

I waive my current coverage effective the first of the month following the 30-days' notice requirement and ending December 31, 2022 in return for a prorated taxable, but not pensionable cash incentive. I understand that I will receive payment in June and December of each year, pursuant to Section 125. I may re-enroll unconditionally effective each subsequent January 1st and I may also re-enroll immediately if I submit proof of a life status change (e.g. employment, death or disability of a spouse, divorce or legal separation, activation to full-time military status, etc.). ***I understand that I am not eligible for the waiver incentive payment if my other coverage is with the SHBP or SEHBP.***

By signing below, I acknowledge that I fully understand the terms of this Group Insurance Waiver Form.

☐ I would like to opt out from the dental plan.

☐ I would like to participate in the dental plan. New enrollment in the dental plan

_____ _____ _____

Employee Signature Printed Name Date

The Contract Agreement between the Jefferson Township Education Association and the Jefferson Township Board of Education and its designated group insurance carrier(s) – will supersede any potential errors or omissions in this document.

If you choose a family pay out, please indicate below the name and date of birth for all dependents:

1. _____

2. _____

3. _____

4. _____

5. _____

***Submit the completed form and any required supporting documentation (copy of insurance card, marriage certificate and birth certificates) to Manal Fouad (mfouad@jefftwp.org) by October 31, 2021.***