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*	
	\$3,000 Annually*	Family	\$4,500 Annually*	
Non-Cash Waiver (f	or employees with alternate	coverage in the SI	HBP or SEHBP)	
Applicant must prov	ide copy of currently activ	e insurance card	as proof of other coverag	je:
Insured's Name:		Policy # _		
Insurance Company	Name:			
*Prorated for New Hires a	nd for employees who waive cove	rage as a result of a qu	alifying life event.	
31, 2022 in return for a June and December of a 1st and I may also re-enspouse, divorce or legal	rage effective the first of the ma prorated taxable, but not pense each year, pursuant to Section roll immediately if I submit pro- separation, activation to full-tir int if my other coverage is with	sionable cash incenti 125. I may re-enroll of of a life status cha me military status, et	ve. I understand that I will rec unconditionally effective each nge (e.g. employment, death o c.). I understand that I am not	eive payment in a subsequent January or disability of a
By signing below, I ackn	owledge that I fully understand	the terms of this Gro	oup Insurance Waiver Form.	
I would like to opt	out from the dental plan.			
I would like to part	icipate in the dental plan. New	enrollment in the de	ntal plan	
	Print between the Jefferson Townsh nated group insurance carrier(s			
If you choose a family p	pay out, please indicate below t	he name and date of	birth for all dependents:	
1				
2				
3				
4				

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.