MEDICAL GROUP INSURANCE WAIVER FORM
JEFFERSON TOWNSHIP BOARD OF EDUCATION

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, 2024 and ending December 31, 2024.

Please check one of the options below. Due to the transition to the SEHBP effective February 1, 2024 you may indicate that the selection will be effective for the month of January 2024, the period February through December 2024, or both.

Plan Description	Annual Waiver Amount*	January 2024	February – December 2024
Single	$1,750		
Parent Child(ren)	$3,000		
2 Adults	$3,500		
Family	$4,500		
Non-Cash Waiver (for employees with alternate coverage in the SHBP or SEHBP)	$0		

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

Insured's Name: ___________________________________Policy # ________________________

Insurance Company Name: ____

*Prorated based on eligibility to receive an incentive payment and the actual number of months of coverage waived.

I waive my current coverage effective the first of the month following the 30-days' notice requirement and ending December 31, 2024 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. Participants are not eligible for Open Enrollment Provisions.

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

☐ I would like to participate into the dental plan.

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

______________________________ ________________________ ____________________

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-