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, 2023 and ending December 31, 2023.

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*

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, 2023 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.**

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 into 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- _____