Effective July 1, 2018

Jackson Township Board of Education
Waiver of Health Benefits - Jackson Township Administrators Association/ Jackson Township Non-Certified Supervisors

151 Don Connor Boulevard, Jackson, NJ 08527
Phone: 732 833 4257

Employee Name: _____ Date of Birth: _____

Social Security Number: _____ Waiver Period: _____

I hereby certify that, on behalf of myself and my eligible dependents (if any), I am waiving my health benefits coverage offered by the Jackson Township Board of Education for the following reason(s):

_____ I am covered under another plan as a spouse or dependent
_____ I am covered by Medicare, non-group or Veteran's program
_____ I am covered under another plan sponsored by a second employer

Subscriber Name: _____

Carrier Name: _____ Group/Policy Number: _____

In return, Jackson Township Board of Education has agreed to reimburse me at the following contracted amount(s). I hereby certify that I understand and agree that my waiver of benefits is of my own volition. It is not based upon representations either from the Jackson Township Board of Education or the Jackson Township Education Association other than the monetary reimbursement indicated. I agree to hold both Jackson Township Board of Education and the Union harmless with regard to any adverse results of my voluntary and informed waiver of benefits. I also certify that I have active health insurance on my own as listed above, and that I cannot waive my benefits through Jackson Township Board of Education if I have no other active coverage. Please provide proof of insurance.

Coverage Type	✓	Medical	✓	Prescription Drug	✓	Dental	✓	All
Single		$485.21		$130.66		$55.99		$671.86
Employee/Child		$862.40		$218.10		$137.35		$1,217.85
Employee/Spouse		$1,224.94		$367.42		$137.35		$1,729.70
Family		$1,224.94		$367.42		$137.35		$1,729.70

Waiver cash payments are payable at 50% in January and 50% in July of the year for which I have opted out, subject to all appropriate deductions. Payments are pro-rated based on the actual number of months I am not covered by the Board plan. This payment is not to be considered a salary payment and, as such, is not pensionable. I understand that this compensation is considered as ordinary income and is taxable as such. I also understand that I must re-enroll for the waiver benefit each year during the annual open enrollment period.

I understand that I may revoke this waiver and re-enroll in Board coverage if a qualifying hardship/change of life circumstance occurs, such as:

- Termination of other coverage
- Termination of employment of person with benefits
- Death, disability, divorce, legal separation
- Change in eligibility or cost of other coverage

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Should I revoke the waiver prior to the end of the term for which I initially opted out, I understand that the reimbursement to which I am entitled shall be pro-rated upon the period of time I am not covered by the Board's benefit plan(s). I further understand that I may restore the benefits for which I am eligible during the next open enrollment period. Such benefits would commence on July 1 of the next plan renewal year.

I am waiving benefits on behalf of myself and the following dependents:

Relationship	Name	Social Security Number	Date of Birth
Self			

Employee Signature: _____ Date Signed: _____

Witness: _____ Date Signed: _____

Two (2) original copies of this waiver shall be signed. The employee shall keep one and the other shall be placed in the employee's personal file.