Morris Hills Regional District Board of Education
Rockaway, New Jersey

Health Insurance Waiver
Administrators, Teachers, Secretaries, Staff Assistants, Trainers
Non-Unit, Security, Bus Mechanics, Custodians, Maintenance

Name: _____

Social Security No. _____

Plan Year: **July 1, 2016 – June 30, 2017**

As a full time employee and member of the Morris Hills Regional District Board of Education Flexible Benefits Plan, I am entitled to elect to participate in the health insurance and dental program offered by the Morris Hills Regional District, or to waive coverage and receive a cash payment instead. I understand that, in order to waive health insurance and dental coverage, **I must return this signed form with evidence satisfactory to the Board of Education that I have a comprehensive health insurance plan in effect, other than the plan offered by the Board of Education, which provides this insurance for me. (Provide dated cards or letter verifying insurance.)**

I understand that I cannot change or revoke my election prior to June 30th unless I have a change in family status (i.e., marriage, divorce, death of a spouse, birth or adoption of a child, termination of employment of a spouse, or such other events as described in the Plan Document).

I further understand that prior to July 1, 2017, I will be offered the opportunity to change my benefit election for the following Plan Year. If I do not complete and return a new election form at that time, I will be deemed to have elected health and dental insurance coverage.

I further certify that I understand and agree that my waiver of the foregoing benefits is of my own volition. It is not based upon representations from the Morris Hills Regional District Board of Education. I agree to hold the Board harmless with regard to any adverse results of my voluntary and informed waiver of the foregoing benefits.

I further agree that if I accept the waiver and then reenroll in the plan based on a change in family status, and such reenrollment occurs before the end of the Plan Year, the payment will be prorated.

I hereby elect the following benefit for the Plan Year shown above.

_____ A. I hereby elect to re-enroll into the medical/dental insurance benefits provided under the Board of Education's Plan **(please contact Human Resources at x2298 for the enrollment form).**

_____ B. A cash payment of $3,000.00 plus waiver of health /dental benefits **(this form with evidence of insurance must be sent to Human Resources).** Check one:

Waiving Health and Dental ____ Waiving Health only _____

NAME OF ALTERNATE HEALTH INSURANCE COMPANY: _____

Note: If you wish to receive Dental only, you will be charged 1.5% of your pay until you have reached the annual premium for dental insurance.

Signed: _____ _____ _____

Employee Spouse/Parent Date

Signed: _____ Date_____

Board Secretary/Business Administrator

PLEASE COMPLETE, SIGN AND RETURN THIS TO FORM TO EILEEN OSBORNE OR MARIA CORRING IN PERSONNEL BY 5/31/2016.