CLIFFSIDE PARK BOARD OF EDUCATION

Group Insurance Waiver Form

Health/RX Waiver Form

In order to waive your health/prescription insurance you must have coverage under a private insurance plan or are already covered under a plan with NJ State Health Benefits. Only if you have covered under a private plan will you qualify to receive a cash payment equivalent to 25% of the amount saved by the Cliffside Park Board of Education or the listed rates below, whichever is the lesser amount. Proof of other coverage must be submitted for eligibility. This amount will be divided into two (2) payments paid in December and June.

Please indicate your preference below:

CASH WAIVER

☐ **I am waiving my New Jersey School Employees Health Benefits/ Optum Rx Prescription coverage for this school year in lieu of a *cash payment.***
Payment Schedule: 50% in December and 50% in June.

Cash Payment: Please indicate coverage below:

☐ **Single coverage (NJ Direct 10) - $1,800 payable in two installments of $900**

☐ **Parent/ Child coverage (NJ Direct 10)- $3,200 payable in two installments of $1,600**

☐ **Employee/Spouse coverage (NJ Direct 10)- $3,400 payable in two installments of $1,700**

☐ **Family coverage (NJ Direct 10)- $5,000 payable in two installments of $2,500**

Proof of other coverage must be provided:

Policy number/Carrier: ____
Copy of Card Received: _________

NON-CASH WAIVER

☐ **I am waiving my New Jersey School Employees Health Benefits/Optum Rx Coverage. I currently have other coverage with SEHB and am aware that *I do NOT qualify* for a cash payment due to Division of Health Benefits regulations.**

Proof of other coverage must be provided:

Policy number/Carrier: ____
Copy of Card Received: _________

DENTAL & VISION

Both plans are voluntary waivers. They are available to the employee at no cost (payroll dedication). No cash equivalent for waiving either one of these plans is available in lieu of coverage. However, should you still wish to waive these plans please indicate below:

☐ **Yes, I am waiving my dental coverage for this school year**

☐ **Yes, I am waiving my vision coverage for this school year.**

I am waiving the various insurance coverage effective _______________ as indicated above. I am aware of the conditions involved with this waiver process. I may enroll unconditionally each open enrollment period or immediately if I submit proof of a life status change (e.g. unemployment, death, disability of a spouse, divorce or legal separation, activation of full-time military status, etc.)

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

_____________________	_____________________	__________
Signature	Print Name	Date