

## **Waiver for the Brick Township Board of Education Premium Conversion Plan**

I understand that I may elect medical, prescription and/or dental coverage through the Brick Township Board of Education Premium Conversion Plan, or alternatively, I can decline coverage and receive the taxable cash benefit as indicated in my current contract. If I do not have coverage elsewhere, I will NOT be eligible for the taxable cash benefit, but I will be permitted to waive coverage if I complete this form. Additionally, according to state law, I understand if my other coverage is coverage through the New Jersey State Health Benefits program, I am not eligible for the taxable cash benefit for medical coverage.

I understand that to be waived from the Premium Conversion Plan I must complete, sign, and return this document to the Business Administrator. I understand that this form must be completed and signed every year in order to be eligible for the taxable cash benefit for that year.

I am electing to waive coverage under the Brick Township Board of Education Premium Conversion Plan. I understand that this election is for the entire calendar year, and I will not be able to re-enroll under the Premium Conversion Plan until an open-enrollment period, unless a qualifying event as defined by the Internal Revenue Code occurs, which allows me to change my elections mid year (i.e. birth of a child or a change in my marital status). I further understand that prior to each calendar year, I will be given the opportunity to change this election during open enrollment. If I do not submit a new waiver form including proof of other coverage each year to the Board during open enrollment, the Board will continue my waiver, but will not pay the taxable cash incentive. Additionally, if I do not submit an application to re-enroll in the Premium Conversion Plan during open enrollment, the Board will not re-enroll me in the plan.

I agree to waive all pre-tax benefits under the Brick Township Board of Education Premium Conversion Plan and I understand that I am not eligible for payment of the taxable cash benefit if I am unable to prove that I have other coverage. I further understand that I am not eligible for payment of the taxable cash benefit for medical coverage if my other coverage is through the New Jersey State Health Benefits plan.

Proof of other coverage

I am declining coverage as indicated because coverage is provided to me through:

Insured's name and SSN#: \_\_\_\_\_

Employer's name where insurance is provided: \_\_\_\_\_

Insurance company (name, policy number, and address): \_\_\_\_\_

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(IMPORTANT: attached a copy of insurance card)

***I understand that if I decline coverage with the Brick Township Board of Education. at this time, and I lose my "other" coverage as a result of employment or another qualifying event as defined by the Internal Revenue Code, I must notify the Administration Office within 30 days of the date of the triggering event, and must provide written proof that I/we are no longer eligible for the insurance identified above. Furthermore, I understand that my insurance as an employee of Brick Township Board of Education will become effective the date of loss of coverage from the triggering event, provided that I have complied with the aforementioned conditions.***

***I further understand that if I decline coverage at this time, I will not be eligible to re-enroll until an open-enrollment period, unless a qualifying event occur, which results in my being ineligible for the "other" group insurance.***

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**Employee's name (please print)**

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**Date**

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**Employee signature**