LONG BRANCH BOARD OF EDUCATION
WAIVER OF HEALTH BENEFITS

Employee's name: _____
Print Name Above

(Check One)
_____ LBSEA, Long Branch School Employees Association
_____ LBFT, Long Branch Federation of Teachers
_____ LBPDA, Long Branch Principals & Director Association
_____ LBSCA, Long Branch Supervisors & Coordinator Association

or
_____ NON-AFFILIATED STAFF MEMBERS

I hereby certify that I am waiving my health benefits coverage under: (Check appropriate level and plan(s)

_____ Single
_____ Employee/Spouse/Dom. Partner
_____ Parent/Child
_____ Family

_____ District's Medical Benefit Plan – INTEGRITY HEALTH
_____ District's Prescription Benefit Plan – BENECARD
_____ District's Dental Benefit Plan – HORIZON BC/BS
_____ District's Vision Care Benefit Plan – NVA

This waiver is in effect for the one (1) year period from January 1, 2023 to December 31, 2023.

I further certify that I understand and agree that my waiver of the foregoing benefits is of my own volition and is not based upon any representations by either the Long Branch Board of Education or my assigned Bargaining Unit, described above, other than the monetary reimbursement, if applicable. I am able to provide proof of medical, dental, prescription, and vision insurance coverage through another source. I agree to hold the Board and the Association harmless with regard to any adverse results of my voluntary and informed waiver of the foregoing benefits.

I understand that I may revoke this waiver prior to the expiration date shown above only under the following hardship circumstances:

- Termination of employment (proof of employment of person with benefits required)
- Legal separation (copy of decree required)
- Group contract/policy terminated of person with benefits (proof of termination required)
- Disability of spouse which eliminates benefits (proof of termination of benefits required)
- Divorce (copy of decree required)
- Death of spouse (copy of death certificate required)
- Military discharge (copy of DD214 required)

Should I revoke the foregoing waiver, I understand that the reimbursement, if applicable, to which I am entitled shall be prorated based upon the period of time I am not covered by the district's benefit plan.

I further understand that I may restore the benefits for which I am eligible if I am no longer covered under my current health care coverage plan(s).

Signed:_____Date:_____
Employee
Witness:_____Date:_____
Personnel Department Designee

Personnel Department verification
of other health benefit coverage: _____
Company Name and Policy Number (attach copy)

_____
Personnel Manager Date

The employee shall maintain one copy of this waiver for his/her records. The Personnel and Payroll Offices shall maintain a copy for department records.