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, 2018 to December 31, 2018.

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 pro-rated 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)

_____
Alisa Aquino, 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.