Important Insurance Waiver Information:

If you are NOT waiving coverage, this does NOT pertain to you.

This packet is for the waiver of health insurance coverage in the upcoming 2024-2025 school year.

Carefully read pages 1 and 2.
Fill out page 3 (Provide copy of insurance cards).
Fill out page 4 (Dependent information).

Upon completion, return pages 3 and 4 to the Board Office.

If you have any questions or concerns, please call Jason Sabolchick at 732-269-2321 ext. 3212 or email at jsabolchick@btboe.org.

Berkeley Township School District

53 Central Parkway – Bayville, NJ 08721
Phone: 732-269-2321 ext. 3212 – Fax: 732-269-4487

WAIVER OF INSURANCE COVERAGE(S) 2024-2025

The Berkeley Township Board of Education (the "Employer") offers a benefits package to its eligible employees. The benefits package includes Medical, Prescription, Dental, and Vision Coverage(s) (the "Plan").

Some employees do not require coverage(s). This is because they are covered under another person's insurance plan. These particular employees may desire to waive their ability to participate in the Plan offered by the Employer. In order to effectuate their intent to waive coverage(s), an employee must sign this waiver form.

WAIVER

A waiver is a voluntary and intentional relinquishment or abandonment of a known existing legal right or benefit which, except for the waiver, a person would have enjoyed. It is a voluntary abandonment by a capable person made with the intent that such a right shall be surrendered and the person be deprived of its benefit. It is a general rule of law that if a benefit is waived, the party waiving it cannot thereafter insist on its performance.

For the consideration recited below (the "Employee") and the Employer agree as follows:

1. **Waiver** – The Employee waives coverage(s) under the Plan which is currently provided to the Employee. The Employee shall not be entitled to any insurance benefits under the Plan after signing this waiver. In addition, the waiver of these insurance benefits involves certain additional restrictions and certain risks as outlined in this agreement and explained below.

2. **Term** – The term of the waiver of coverage(s) is a 12-month period beginning July 1, 2024 and ending June 30, 2025. It is understood that the Employee must complete and sign a new waiver each year. In the event of a change in circumstances, the Employee will be allowed to revoke this waiver and return to the Plan, subject to further restrictions, as outlined below. The Employee is encouraged to review his/her insurance coverage(s) needs annually in conjunction with any other annual elections of the Employee.

3. **Indemnification** – The Employee knowingly makes this waiver and agrees to unconditionally indemnify, defend, save, and hold harmless the Employer from and against any and all liabilities, losses, damages, costs, and expenses, including reasonable attorneys' fees that the Employee incurs or may incur as a result of this waiver. The Employee also agrees to indemnify the Employer's insurance carriers with the same terms and provisions as indicated in these sections.

4. **Eligibility** – The Employee acknowledges that the waiver of coverage(s) evidenced by this agreement may create significant obstacles to the Employee's further eligibility for insurance coverage(s). Specifically, a circumstance may arise where the Employee, or a dependent of the Employee, develops a condition after the waiver form is executed and prior to the Employee's desire to re-enter the Plan. The revocation of this waiver will not automatically reinstate coverage(s) as explained below. In addition, this waiver may affect coverage(s) that would have been available to individuals related to the Employee through the operation of any federal or state laws.

5. **Reinstatement** – Reinstatement is available only during Open Enrollment or due to a change of life event. The Employee may be reinstated in the Plan by revoking this waiver and notifying the Employer of the Employee's revocation as well as the Employee's intention of seeking reinstatement. However, the Employee will not be allowed to opt back out of the Plan for that period. The Employee must execute any forms reasonably

required by the Employer or the insurance carriers to begin reinstatement procedures. The Employee acknowledges that the Plan may have been terminated or altered during the time period in which the waiver was in effect. The Employee's renewed participation in the Plan is also subject to any approval required by the Employer's carriers, including any exclusions dictated by that carrier for any pre-existing conditions. It is anticipated that there will be a period of time between the Employee's application for reinstated insurance coverage(s) and the granting of coverage(s), if possible, in order to assess the Employee's eligibility. The Employer will require a Certificate of Insurance from the Employee as proof of loss of other coverage(s). The insurance carriers may require a waiting period prior to reinstating coverage(s).

6. **Cooperation** – The Employee agrees to cooperate with the Employer both in execution of this form and in the administration of any changes to the Employee's status regarding the Plan.

7. **Plan Amendments** – The Employee acknowledges that the Employer is not legally bound to provide insurance coverage(s). The Employer is permitted to make alterations to the Plan, including termination of the Plan, at any time including the time during which this waiver is in effect.

8. **General** – This agreement shall be binding on the Employee, those who would be entitled to the Employee's benefits through the application of any federal or state law, and the Employee's respective legal or personal representatives, heirs, executors, administrators, successors, and assigns. In the event that any one or more of the provisions of this agreement shall be held to be invalid, the agreement of the Employer and the Employee with reference to the subject matter contained herein shall be void. The agreement may not be modified, altered, or amended except in writing and executed by the Employer and Employee. This agreement shall be governed by and construed in accordance with the laws of the State of New Jersey.

Health Benefits Waiver Application

I acknowledge that I have been offered the opportunity to purchase group health coverage through **Berkeley Township Board of Education** for myself and my dependents.

Please check the appropriate box for the benefits you wish to waive:

MEDICAL ☐ PRESCRIPTION ☐ DENTAL ☐ VISION ☐

If you are waiving benefits for yourself or dependents due to having other health care coverage, you may enroll yourself or your dependents in our group health plan during the next open enrollment period. You may be able to enroll yourself and dependents prior to open enrollment due to a qualifying event such as loss of coverage. Employees must give notice and submit the necessary paperwork to the employer within **60 days** of a qualifying event.

MEDICAL (Attach copy of insurance card)

Name of Insurance Company _____ Group/Policy# _____

Name of Employer Providing this Insurance Coverage _____ Type of Coverage (Single, P/C, M/S, Family) _____

Name of the Person under whom I am Covered _____ Relationship _____

PRESCRIPTION (Attach copy of insurance card)

Name of Insurance Company _____ Group/Policy# _____

Name of Employer Providing this Insurance Coverage _____ Type of Coverage (Single, P/C, M/S, Family) _____

Name of the Person under whom I am Covered _____ Relationship _____

DENTAL (Attach copy of insurance card)

Name of Insurance Company _____ Group/Policy# _____

Name of Employer Providing this Insurance Coverage _____ Type of Coverage (Single, P/C, M/S, Family) _____

Name of the Person under whom I am Covered _____ Relationship _____

Having read the Waiver of Insurance Coverage relative to the Voluntary Waiver Incentive Program for Insurance Coverage, I make the following waiver which will become effective on _____

(Date) _____ BY: _____ Employee's Signature

_____ Please Print Name

Health Benefits Waiver Application (Proof of Dependents)

WAIVED BENEFITS: **Please circle the coverage you wish to waive**

Medical	Single	Member/Spouse	Family
Prescription	Single	Member/Spouse	Family
Dental	Single	Member/Spouse	Family
Vision	Single	Member/Spouse	Family

If waiving other than single coverage, please list the eligible dependents and their information below:

(Name)	(Date of Birth)	(Social Security #)	(Relation)
(Name)	(Date of Birth)	(Social Security #)	(Relation)
(Name)	(Date of Birth)	(Social Security #)	(Relation)
(Name)	(Date of Birth)	(Social Security #)	(Relation)
(Name)	(Date of Birth)	(Social Security #)	(Relation)

**Dependent children age out limit for Medical/Prescription is age 26*
**Dependent children age out limit for Dental/Vision is age 26*
**If waiving Medical/Prescription/Dental you must provide proof of coverage (No proof required for Vision)*

DATE

NAME (Please Print)

JOB TITLE (Please Print)

SIGNATURE