**NAME:**_____ **DATE:**_____

**HADDON TOWNSHIP BOARD OF EDUCATION**
**2017-2018 WAIVER OF PARTICIPATION**
**CAFETERIA PLAN BENEFIT ELECTION FORM**

Please check:

- o I waive health insurance coverage for participation in the cash payment plan for the School Year 2017-2018 .

Section 125 "Cash Out" Option for health insurance facts.
Since 1/1/96, the Haddon Township Board of Education has offered a "cash out" option through a Section 125 cafeteria plan for the declination of health insurance coverage. Via this plan, an eligible employee who has health insurance coverage through another source may choose to withdraw from the Board of Education health insurance plan. If the employee chooses this option, he/she will receive a cash payment in the form of a stipend, payable in June. The stipend consists of 1/3 of the cost of the family premium coverage for the current traditional plan.

1. The cash out is based on a school year. (7/1-06/30) The benefit will be paid on June 30.
2. The cash payment will be considered income and applicable taxes will be withheld. The payment will be a payroll check.
3. To enroll or withdraw, the employee must complete forms through the Board office. One of these forms to enroll is to certify that the employee and all dependents are covered through another source.
4. The waiver is for medical health insurance coverage only. It does not affect dental or prescription benefits. An employee who is entitled to medical benefits may still continue to receive dental and prescription coverage unless he/she declines such coverage.
5. An employee who "opts out" may re-enroll for medical coverage only under the following conditions:
    a. Open enrollment for the next school year
    b. Change of status as defined in the negotiated agreement which causes coverage to be lost (notice must be provided within 60 days of the event causing loss of coverage)
        i. Termination of employment
        ii. Divorce(copy of decree required)
        iii Death(certificate required)
        iv. Group contract policy terminated
        vi. Military discharge(form DD124 required)

    Cash payment for those who re-enroll because of the above will be pro-rated. Payment will be made in June.

PRINT NAME _____

SIGNATURE _____ DATE _____

**HADDON TOWNSHIP BOARD OF EDUCATION**
**WAIVER UNDER CAFETERIA PLAN FOR PARTICIPATION**
**IN THE HEALTH BENEFIT PLAN FOR 2017-2018 SCHOOL YEAR**

WHEREAS, in accordance with the cafeteria plan (the "Plan"), the Employee has elected to waive coverage for himself or herself and his or her eligible dependents of the health and hospitalization insurance which the Employee would otherwise be entitled to received pursuant to the collective bargaining agreement ("Agreement"), and

WHEREAS, such waiver is knowing and voluntary on the part of the Employee;

NOW, WHEREAS, in consideration of the promises contained herein, and subject to the provisions of the Plan, it is hereby agreed as follows:

1. Waiver of Participation in Health and Hospitalization Insurance Benefit - In accordance with the Plan, the Employee, for himself or herself, his or her heirs, assigns, successors, spouse, and dependents hereby waives any right on his or her part of his or her spouse and dependents to participate in the health and hospitalization insurance benefit maintained by the Employer. In making this knowing and voluntary waiver, the Employee on behalf of himself or herself, his or her spouse and dependents understand and agrees that they will have no coverage or benefits whatsoever under the health and hospital insurance and that this waiver may not be revoked, except to the extent permitted under the Plan in the event of a change in family status.
2. Release and Indemnification - The Employee, for himself or herself, his or her heirs, assigns, successors, spouse and dependents covenants and agrees never to make a claim under the health and hospitalization insurance and further fully releases the Employer, its officers, directors, employees and agents and insurance carriers from any liability arising in connections with any claim by the Employee, his or her heirs, assigns, successors, spouse and dependents for any benefits or coverage under the health and hospitalization insurance, and the Employee, for himself or herself, his or her heirs, assigns, successors, spouse and dependents agrees to defend and indemnify the Employer, its officers, directors, employees and agents from any liability, loss, damages, costs or expenses (including, but not limited to, attorneys' fees) arising in connection with this waiver or any claim for benefits or coverage under the health and hospitalization insurance.
3. Waiver Irrevocable, Except Upon a Change in Family Status - Employee acknowledges and agrees that his or her decision to enter into this Waiver is knowing and voluntary, that he or she fully understands all the provisions of this Waiver and that this Waiver may be revoked only to the extent permitted under the Plan and the Agreement in the event of a change in family status.
4. No Representations by Employer as to Possible Tax Consequences - Employer has made no representations to Employee with regard to the tax consequences of this Agreement and the Employer shall have no liability with regard to any such tax consequences.
5. Certification of Other Insurances - The Employee hereby certifies that he or she has existing and in effect other health and hospitalization insurance which provides coverage for himself or herself and for his or her eligible dependents.
6. Sealed Instrument -This Agreement shall constitute a sealed instrument under New Jersey Law,

**IN WITNESS WHEREOF,** the Employee designated below has entered into this

Waiver this _____day of _____2017.

The Employee Name _____
(Signature) (Print)

**HADDON TOWNSHIP BOARD OF EDUCATION**
**VERIFICATION OF OTHER MEDICAL COVERAGE**
(PLEASE PROVIDE PROOF OF INSURANCE COVERAGE)

Employee's Name _____ Social Security # _____

Marital Status: _____# of Dependents: _____

I understand that I am eligible for medical benefits provided by the Haddon Township Board of Education's Medical Plan. These medical benefits and the contributions I would have to make to be covered for these benefits have been specifically explained to me. I certify that I and/or my dependents have medical benefits under another group insurance plan:

NAME OF ORGANIZATION PROVIDING COVERAGE:

_____

ADDRESS _____

INSURANCE CARRIER _____GROUP # _____

**** Please attach copy of insurance card or other proof of coverage.****

I, therefore, decline coverage under the Haddon Township Board of Education Medical Plan for my dependents and myself.

I waive all claims to medical benefits under the Haddon Township Board of Education Medical Plan. This waiver of coverage will remain in force for the plan year unless my family status changes.

I declare that the information I have furnished above is true, correct and complete to the best of my knowledge and belief.

_____

Employee's Signature Date

_____

Witness Date