

MATAWAN-ABERDEEN REGIONAL SCHOOL DISTRICT
2022/2023 Health Benefits Waiver for employees in the teacher, clerical, maintenance
and bus driver bargaining units.

Employee Name: _____ Date of birth: _____
Social Security Number: _____ Date of hire: _____
Marital Status: Single _____ Married _____ Widowed _____ Divorced _____

I was given the opportunity to enroll in Group Health Benefits by my employer. Employees in the teacher, clerical, maintenance and bus driver bargaining units **MUST waive prescription and medical together.**
Employees can no longer waive one or the other.

I hereby agree to waive the following health benefits from the Matawan-Aberdeen Regional School District.
_____ **Medical** Coverage (Horizon BCBS) & **Prescription** Coverage (Benecard)
_____ **Dental** Coverage (Delta Dental)

Check the level of coverage you are eligible to waive:

Single _____ 2 Adults _____ Family _____ Parent/Child _____

Reason for refusal:

_____ Other group coverage * sponsored by my spouse's employer.

_____ Other group coverage * sponsored by another organization.

_____ Other reason: please explain: _____

* Please provide name of carrier: _____ Policy Number _____

Waiver reimbursements are calculated by **multiplying the premium** of the NJEHP medical plan (single, 2 adults, family, parent/child) which corresponds to the waiver level requested, **times 25%** (not to exceed \$5000). *Note: Payments are paid in January and June and are prorated for employees who waive coverage during the current school year.*

I further agree that I will indemnify and hold harmless the Board of Education and the MatawanAberdeen Regional Education Association from any and all claims as a result of any impact this waiver may have on me or my family members.

I understand that: I will need to provide a **copy of proof of other current insurance**; and that neither I nor any of my dependents will have coverage for the period of July 1, 2022 through June 30, 2023.

If waiving family, parent/child, 2 adults coverages, **proper documentation is required**: marriage certificate, birth certificates of dependents. **Waiver forms must be resubmitted each benefit year**, no need to resubmit documents each year (marriage license, birth certificates), *but a signed waiver form with proof of coverage is still required each year.*

I also understand that: I can resume coverage due to involuntary loss of my other coverage; and I will need to provide to my employer a copy of the proof of the loss of other coverage within 60 days of the loss of other coverage.

Signature of employee _____ Date _____