CLIFFSIDE PARK BOARD OF EDUCATION
Group Insurance Waiver Form

HEALTH/RX WAIVER FOR SCHOOL YEAR 2022-2023

In order to waive your health/prescription insurance you must have coverage under a private insurance plan or are already covered under a plan with NJ State Health Benefits. Only if you are covered under a private plan will you qualify to receive a cash payment equivalent to 25% of the amount saved by the Cliffside Park Board of Education or the listed rates below, whichever is the lesser amount. Proof of other coverage must be submitted for eligibility. This amount will be divided into two (2) payments paid in December and June.

Please indicate your preference below:

CASH WAIVER ☐ I am waiving my New Jersey School Employees Health Benefits/OptumRx Prescription coverage for the school year 2022-2023 in lieu of a ***cash payment***. Payment Schedule: 50% in December 2022 and 50% in June 2023.

Cash Payment: Please indicate your coverage below:

☐ Single coverage (NJ Direct10) - $1,800 payable in two installments of $900

☐ Parent/Child coverage (NJ Direct10) - $3,200 payable in two installments of $1,600

☐ Employee/Spouse coverage (NJ Direct 10) - $3,400 payable in two installments of $1,700

☐ Family coverage (NJ Direct10) - $5,000 payable in two installments of $2,500

Proof of other coverage must be provided:

Policy number/Carrier_____
Copy of card received:_____

NON-CASH WAIVER ☐ **I am waiving my New Jersey School Employees Health Benefits/OptumRx coverage for the school year 2022-2023. I currently have other coverage with SEHB and am aware that *I do NOT qualify* for a cash payment due to Division of Health Benefits regulations.**

Proof of other coverage must be provided:

Policy number / Carrier_____
Copy of card_____

DENTAL & VISION:

Both plans are voluntary waivers. They are available to the employee at no cost (payroll deduction). No cash equivalent for waiving either one of these plans is available in lieu of coverage. However, should you still wish to waive these plans please indicate below:

☐ Yes, I am waiving my dental coverage for the 2022-2023 school year.

☐ Yes, I am waiving my vision coverage for the 2022-2023 school year..

I am waiving the various insurance coverage effective _____ as indicated above. I am aware of the conditions involved with this waiver process. I may enroll unconditionally each open enrollment period or immediately if I submit proof of a life status change (e.g., unemployment, death, disability of a spouse; divorce or legal separation; activation to full-time military status, etc.)

By signing below I acknowledge that I fully understand the terms of this Group Insurance Waiver Form.

_____ _____ _____
Signature Print Name Date