# SOUTHERN FULTON SCHOOL DISTRICT
# WAIVER OF HEALTH CARE COVERAGE PLAN
# 2018-2019 ELECTION FORM

You have the opportunity to participate in the Southern Fulton School District Insurance Plan (the "Plan") and elect to receive additional taxable compensation in lieu of health insurance coverage. Complete Section 1 by printing your name and providing your social security number, sign at the bottom, and return this Election Form to the Plan Administrator. Your compensation will be increased in the amount as listed in Section 2. Only those individuals, who are eligible to participate in the Southern Fulton School District Health Insurance Plan and are enrolled in another group medical plan, such as a spouse's employer's plan, are eligible to receive the Waiver Payment under this Plan.

**Irrevocable Election.** If you choose to participate in this Plan, you can not change or revoke your election until the next open enrollment period for the next Plan Year that runs from July 1, 2019 to June 30, 2020 unless you have a change in status as described in the Plan. Examples of a change in status are: marriage, divorce, death of your spouse or child, birth or adoption of a child, termination of employment of your spouse, switch from part-time to full-time employment or from full-time to part-time employment, beginning an unpaid leave of absence, or where there has been a significant change in your or your spouse's health coverage attributable to the spouse's employment. The election change must be requested within 30 days of the event, and must be on account of and consistent with the change in status as defined in the Plan.

## 1. Employee Information

Name: _____ SS#: _____

## 2. Waiver Compensation

By waiving participation in the health insurance plan, I understand my increased taxable compensation during the Plan Year will be paid in the amount of $2,500.00 with payment made the last pay period in June of the school year just completed. This amount will be calculated on a pro-rated basis when waiver compensation is elected or eligibility ceases, and the period of participation is less than 12 months.

## 3. Eligible Participant Statement and Signature

I hereby elect to participate in the Plan for the duration of the Plan Year. I am covered for health care under another group plan as documented by my submission of such coverage to the Plan Administrator. I attest that all other members of my expected tax family (i.e., those individuals whom I reasonably expect to claim a personal exemption deduction) are likewise covered under the same alternative group plan that I have submitted, or otherwise have minimum essential coverage that was not obtained in the individual market or Marketplace. I acknowledge that I have read and understand any material (including the Summary Plan Description) concerning the effect of my election. I further understand that by this election, I agree to hold Southern Fulton School District harmless from any medical claim expenses incurred subject to group/individual health insurance plan coverage on my eligible dependents or myself. My election on this Election Form revokes any prior election relating to the same matter under the Plan. Before the beginning of each Plan Year, I will be offered the opportunity to change my election for the following Plan Year.

This Election Form is subject to the terms of the Plan as in effect from time to time and shall be governed by and construed in accordance with the laws of the State of Pennsylvania to the extent not superseded by Federal law.

_____ _____

Employee's Signature Date

**Administrator Use Only:**

☐ **Proof of other coverage received** **Date:** _____ **Received by:** _____