BALDWINSVILLE CENTRAL SCHOOL DISTRICT

Acknowledgement of Offer and Optional Waiver to Decline Health Insurance Coverage

EMPLOYEE NAME:_____ ELIGIBILITY DATE: _____

I acknowledge that Baldwinsville CSD informed of the terms of availability of medical and dental coverage under the Baldwinsville CSD health plans as an employee of the District. I understand that my eligibility is subject to the requirements of the collective bargaining agreement in place for my position.

I understand that in order to elect coverage I must submit completed and signed enrollment form(s) and all required support documentation to the Human Resources Office within 30 days of my benefit qualification date (ex. hire date). Required support documents include social security cards, birth certificates, adoption records, marriage license, custody agreements, court orders, Medicare cards and other coverage id cards . Failure to complete the enrollment process within the timeline will be interpreted as declining coverage. My next opportunity to enroll in benefits will be during the next open enrollment period, unless I experience a qualifying life event. If my employment should end while enrolled in benefits, I understand that my benefits will be terminated effective with my last day of paid service with the District and that an offer of continuation coverage under the provisions of COBRA will be extended as required by law.

Alternatively, I understand that I have the right to decline coverage. The next opportunity for me to enroll in benefits will be during an open enrollment period, unless I experience a qualifying life event. Life event examples include the involuntary loss of other coverage and the gain of a new dependent through birth, adoption or marriage. I have been informed that in order to enroll in benefits as a result of a life event I must submit enrollment form(s) and required support documentation to the Human Resources Office within 30 days of the effective date of change and if I fail to meet the 30-day deadline, I must wait until open enrollment. If I decline to participate in the benefits offered, I understand that I will not be eligible for COBRA continuation coverage if my employment should end. I have been informed that if I decline this offer of coverage I may be subject to loss of federal and/or state government subsidies and/or penalties.

ELECTIONS:

☐ I elect to ENROLL in the District's medical and dental plans.

☐ I elect to ENROLL in the District's medical plan only.

☐ I elect to ENROLL in the District's dental plan only. I decline to enroll in medical coverage for the reason indicated below.

☐ I elect to DECLINE all District sponsored coverage at this time for the reason indicated below.

REASONS:

☐ I am already enrolled in District medical coverage as a dependent of _____.

☐ I am covered under another group health plan or dental plan not offered by the District (through a spouse, parent, etc.)

Carrier: _____ Member Id: _____ Policyholder: _____

☐ I am currently ineligible as outlined in the collective bargaining agreement and minimum eligibility rules.

☐ I am Medicare eligible.

☐ I do not want coverage offered through this employer (reason must be provided):_____.

EMPLOYEE SIGNATURE **TODAY'S DATE**