CHAGRIN FALLS EXEMPTED VILLAGE SCHOOLS

MEDICAL BENEFITS WAIVER FORM

An employee may waive medical (including dental) benefit coverage for the entire school year and receive a waiver payment. *An employee's eligibility for the waiver is based upon contracted hours, with payment amounts pro-rated based on percentage of full-time.* ***Employees with spouses who also are employed by the Board are not eligible for the waiver payment.*** *The number of members eligible for waivers on June 30 shall determine the amount paid as follows:*

0 – 30 waivers	*$1,000*
31 + waivers	*$2,000*

New employees hired during the school year are eligible to participate at a pro-rated annual payment.

The waiver payment shall be paid in the second pay in July following the waiver year.

This form must be completed and returned to the Treasurer's Office by ***September 16, 2018*** to be eligible for participation. Waiver payments will not be paid unless the employee shows proof of medical and prescription drug coverage under another group plan.

I, _____, do hereby voluntarily waive the medical and dental benefits offered by my employer, Chagrin Falls Exempted Village School District, for myself and/or for my eligible dependents. All persons waiving coverage are listed below:

_____ _____

_____ _____

The medical/dental benefits provided by my employer have been explained to me. I understand that by waiving my rights to this medical/dental coverage, I cannot make claim against my employer or the health plans, through which my employer offers coverage, for any and all health-related claims the persons listed above and myself may have while not covered by the medical benefits. I certify that I am waiving my right to medical/dental coverage through my employer because my dependent's and/or I have medical coverage through:

_____

(A PHOTOCOPY OF MY CURRENT HEALTH INSURANCE IDENTIFICATION CARD IS ATTACHED)

By waiving my rights to this medical coverage, I further understand that I and/or my dependents (including my spouse) will not be eligible to obtain coverage under my employer's health plans until the next open enrollment period.

_____ _____

Employee Signature Date

_____ _____

Treasurer's Signature Date