To: All Full-Time Employees

From: Keisha Martinez, Health Benefits Specialist

RE: Health Insurance Buy-Out 2017-2018

Date: May 1, 2017

If you are eligible to be insured under your working spouse’s health insurance plan, you may opt out of the District health insurance effective, September 1, 2017. **Everyone** who participates in the buy-out must submit a new buy-out form each year and provide proof of other health insurance coverage at the time of request. If both spouses are eligible for insurance through the Newburgh Enlarged City School District, only one Buy-Out may be requested.

Buy-Outs are paid each October for the current school year.The Buy-Out for active employees will be paid through payroll at the rate of $800.00 for support staff and $1500.00 for teachers, teaching assistants and administrators. Appropriate deductions will be made. The Buy-Out for retired teachers will be paid the last payroll in October. **Please note**: **Buy-Outs for new hires are pro-rated.**

During the year, you may resume insurance coverage if necessary. You may re-enter the plan immediately if the reason is due to a qualifying event such as a change in family status or loss of employment. **Otherwise, you must wait three months after you provided notice of your wish to re-enter the District’s health insurance plan.** If you are currently participating in the buy-out and wish to re-enter the District’s health insurance plan, please contact my office for an insurance enrollment form. You must also submit a letter requesting re- entry into the District’s health insurance plan.A payroll deduction will be made for each month of the restored coverage to recoup the Buy-Out previously paid. In addition, if your employment should end during the current school year, you are responsible for reimbursing the District a pro-rated amount of the Buy-Out previously paid to you.

If you wish to participate in the Health Insurance Buy-Out for the 2017-2018 school year, please complete the attached form and send a copy of your current health insurance card to the Health Benefits Department at the Board of Education, by June 16, 2017. If you and your spouse will be retiring soon, please remember that the surviving spouse of our employee must pay the full cost of coverage. Therefore, it may be advisable for your spouse to be enrolled in an individual health insurance plan with his/her own employer.

**DECLINATION OF HEALTH INSURANCE FORM**

By signing this document, I am electing not to enroll under any of the health insurance options available through the Newburgh Enlarged CSD for the 2017-2018 school year. I understand that by declining at this time:

1. I may subject myself and/or dependents to certain applicable waiting periods should I decide to enroll at a later date.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number (Last 4 Numbers): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2017-2018 Health Insurance Buy-Out Form**

Please answer each question and return the completed form to Health Benefits:

 Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Employee Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Employee First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Building Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Birthday Month: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Circle One: Administrator Civil Service Mgr Conf Retiree Teacher Teaching Assistant

Name and relationship of Insured Person whose health plan you are listed on as a dependent:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birthday Month of Insured Person:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current number of eligible dependent children covered under your health insurance plan:

\_\_\_\_\_\_\_

Please list insured person’s employer or former employer if retired:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list the complete name and address of the health insurance plan you are currently enrolled in as a dependent:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Impt: Please provide a copy of your current health insurance card which lists you as a dependent and attach to this form.**