SOUTH HARRISON TOWNSHIP ELEMENTARY SCHOOL DISTRICT
WAIVER OF HEALTH BENEFITS

This waiver is in effect for the one (1) year period of July 1, 2024 through June 30, 2025. This waiver is contingent upon negotiations.

Name **(Please Print)** _____

As you are aware, the South Harrison Elementary School District Board of Education, allows employees who provide certification of coverage under a spouse's policy, to decline coverage and will be reimbursed at the established portion of the Board's premium.

If you meet the above criteria and are interested in participating, please complete the information below and return to Human Resources, ***along with confirmation of other coverage***.

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WAIVER

A waiver is a voluntary and intentional relinquishment or abandonment of a known existing legal right or benefit, which, except for the waiver, a person would have enjoyed. It is a voluntary abandonment by a capable person, made with the intent that such right shall be surrendered and the person be deprived of its benefit. It is a general rule of law that if a benefit is waived, the party waiving it cannot thereafter insist on its performance. This waiver incentive is not available to employees whose other means of coverage would be via another individual enrolled in a SHBP/SEHBP medical plan, in accordance with the applicable statute and regulations.

I understand that I may revoke this waiver prior to the expiration date shown above only under the following hardship/change of life circumstances:

- Termination of employment of person with benefits (copy of loss of benefits required)
- Legal Separation (copy of decree required)
- Group contract/policy terminated of person with benefits (proof of termination required)
- Disability of spouse which eliminates benefits (proof of termination of benefits required)
- Divorce (copy of decree is required)
- Death of Spouse (copy of death certificate required)

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WAIVER (Check appropriate level and coverage for each waiver)

Administrative Approval

_____Business Adm. _____Date

Medical

___Single ___Husband/Wife ___Family ___Parent/Child(ren)

Prescription

___Single ___Husband/Wife ___Family ___Parent/Child(ren)

Dental

___Single ___Husband/Wife ___Family ___Parent/Child(ren)

1095-C Information: Please list all dependents and spouse who would be eligible for health benefits in your household.

Dependent Name	Social Security Number	Birthdate (only if a SS# is not available)

I certify that I meet the criteria established by the South Harrison Township Elementary School District Board of Education and I am waiving the coverage(s) indicated above provided by the Board. I also understand that payment will be made on June 30th and that it is subject to all appropriate deductions.

_____ _____

Employee Signature Date