MAPLE SHADE BOARD OF EDUCATION

Administration Building
170 Frederick Avenue, Maple Shade, N.J. 08052-3299

Beth Norcia
Superintendent of Schools

Michael Blake
Business Administrator/Board Secretary

For **2024/2025** School Year, I am waiving the following coverage: **O** Medical **O** Prescription **O** Dental

- **Attached is proof that I am covered under another medical plan**
- **Listed below are the names and birth dates of my eligible dependents**

Self:

Spouse:

Dependent # 1

Dependent # 2

Dependent # 3

Dependent # 4

Dependent # 5

Dependent # 6

I understand the following:

1. I may not re-enroll in benefits coverage until the next open enrollment period, except in certain circumstances subject to carrier determination.
2. This waiver reimbursement is subject to all applicable taxes.
3. I agree to hold both the Board and the Association harmless with regard to any adverse results of my voluntary and informed waiver of the foregoing benefits.
4. Employees must meet benefits eligibility criteria to be eligible for waiver of health benefits. (Contracted minimum work of 30 hours)
5. Chapter 2 P.L. 2010 (eff. May 21, 2020) changed the following guideline:
    a. Medical waiver payments are limited to the lesser of: 25% of the SAVED cost or $2,500 annually. Prescription and dental waiver payments are limited to the lesser of: 50% of the SAVED cost of $2,500 annually. The SAVED cost is the premium total of medical PLUS prescription and dental reduced by the calculated employee contribution (greater of: 1.5% of Salary of Phase-In Table Calculation). The $2,500 cap is all-inclusive of medical, prescription and dental.
    b. Must waive BOTH medical and prescription to be eligible for waiver payment.
    c. Must waive BOTH medical and prescription to avoid paying health deduction.
6. This waiver reimbursement will be made to those individuals electing to waive benefits coverage during open enrollment only. If an employee elects to terminate their health benefits coverage during the year, other than open enrollment time, they shall not be eligible for the payment, however they can still elect to terminate their health benefits coverage.
7. I understand that if for any reason, my dependent status changes, I will notify Payroll immediately. I will be responsible for returning any waiver reimbursement that I received in error.

****IMPORTANT - Employee: Please read the following information before signing.**
By signing, I attest I have provided a copy of my current medical insurance card and, if applicable, a list of my eligible dependents with their birth dates. If I fail to provide the requested information, my waiver request will not be processed.

Employee Name: (Please Print):

Employee Signature:

Date:

PLEASE RETURN COMPLETED FORM TO THE PAYROLL OFFICE