HARRISON CENTRAL SCHOOL DISTRICT

REQUEST FOR WAIVER OF SCHOOL DISTRICT HEALTH COVERAGE
AND
CERTIFICATION OF OTHER HEALTH COVERAGE

I, _____do hereby elect to waive my health
(PLEASE PRINT NAME)

insurance coverage with the Harrison Central School District effective _____, for a period of one year in exchange for payment of 50% of the net savings in premiums that would be expended on my behalf taking into account any retirement or social security that must be paid on this amount (see contract for payment schedule).

I acknowledge that I have reviewed the contract clause pertaining to this option (Article XVIII, 18.2A of HAA contract, Article XXB.7 of HAT contract, Article XVI.3 of CSEA contracts or Article XIII.4 of Teacher Aides contract) and understand my benefit options under this contract provision.

I also certify that during this period I will be covered under another health plan under my spouse or relative. This plan meets requirements of Affordability and Minimum Value.

TO BE COMPLETED BY EMPLOYEE

I certify that I am eligible for single _____
2 person family _____
family coverage _____

Spouse _____

Eligible
Dependents _____ _____
(under age of 26) _____ _____

_____ _____
Date Signature of Employee