☐ *New Enrollment* ☐ *Waiver* ☐ *Change:*
Please check off reason to right

- ☐ *Termination of Employment*
- ☐ *Marriage (Add Spouse)*
- ☐ *Divorce (Delete Spouse)*
- ☐ *Add Dependent*
- ☐ *Delete Dependent*
- ☐ *Other_____*

EMAIL FORM TO: lisa.jones@motsd.org

MOUNT OLIVE SCHOOL DISTRICT

Employee Benefits
Direct 15 Worksheet

The District and I hereby agree that I have 30 days to elect Medical, Prescription, and Dental coverage and that my compensation will be reduced, on a pre-tax basis, as required by P.L. Chapter 78 for each pay period during the plan year (or during such portion of the year as remains after the date of this agreement).

Please check off your choices for 2019 / 2020

Circle one

Employee Name: _____ **Male / Female**

Address: _____ City _____ Zip _____

SSN: - - _____ Date of Birth: / /

Home Phone # : ( ) -

If you are enrolling dependents on any employee benefits or WAIVER, please complete below.

	Circle one		
Spouse:	**M/F**	Spouse SSN: - -	Spouse DOB: / /
Child:	**M/F**	Child SSN: - -	Child DOB: / /
Child:	**M/F**	Child SSN: - -	Child DOB: / /
Child:	**M/F**	Child SSN: - -	Child DOB: / /

	Employee	Employee & Spouse	Employee & Child(ren)	Family	Waiver
Horizon Blue Cross Blue Shield of New Jersey	(PER BI WEEKLY PAYCHECK)				
Direct 15 Medical and Prescription	☐	☐	☐	☐	☐ **Waiver**
*If you have other medical coverage, please write it here: _____					
DELTA DENTAL					
DeltaCare DHMO USA	☐	☐	☐	☐	☐ **Waiver**
* If you elect the DHMO, please write your preferred dentist's name here: _____					
Dental PPO + Premier	☐	☐	☐	☐	
eyeMed	(RATES BELOW ARE MONTHLY)				
Vision - *New Benefit as of 7/1/19*	☐ $5.00	☐ $6.00	☐ $6.00	☐ $6.00	☐ **Waiver**

ELECTION / CHANGE

I cannot change or revoke these healthcare choices at any time during the plan year unless I have a change in family status (including marriage, divorce, death of a spouse or child, birth or adoption of a child, termination or commencement of employment of a spouse, or such other events as the Plan Administrator determines will permit a change or revocation of an election). Open Enrollment will occur annually and I will be able to make changes during that time.

WAIVER OF HEALTH BENEFIT COVERAGE

Eligible employees have the choice to waive health coverage (medical, prescription, and/or dental insurance) as long as the employee certifies that he/she has other medical coverage. Each school year, eligible employees may choose to "opt-out" of the district's insurance benefits. Employees choosing to "opt-out" will be required to sign this release indicating that their spouse and/or dependents are covered under another health benefit program. Employees shall be told how to re-enroll in health benefits if needed, and members are responsible for informing the Business Administrator, in writing, of any changes in circumstances regarding health benefits. This applies to new hires after July 1st and any employment termination that is effective prior to June 30th. For the 2019/2020 calendar year, the Board shall pay "opt-out" at the negotiated amount.

Type of coverage I am entitled to: ☐ Single ☐ EE/Sp ☐ EE/Child(ren) ☐ Family

For any benefits I am waiving, I recognize the following criteria for re-entry to the insurance program:

1. Employees and their family members have the option to waive or re-enter the health insurance programs by completing an enrollment application during the annual open enrollment period.
2. The decision to waive coverage cannot change until the next June 1st annual open enrollment period. Since most employees electing to waive coverage will be doing so because they have coverage through their spouse, a "hardship provision" for re-entry is available. This provision allows employees and family members, to re-enter the program, an on immediate basis, without the necessity of health questionnaires. The provision allows for re-entry only in the following situations which result in the loss of coverage through a spouse.

* Termination of Employment
* Divorce (copy of decree required)
* Legal Separation (copy of decree required)
* Death (copy of certificate required)
* Group Contract / Policy Terminated
* Military Discharge (Form DD214 required)

Please Note: To be eligible for the "opt-out" waiver-election, proof of alternative coverage *(copy of current health insurance ID card, etc.)* must accompany this form.

Employee Signature is REQUIRED for any enrollments/changes/waivers using this form

Employee Signature _____ Date _____

Print Employee Name _____

Business Administrator _____ Date _____

Office Use Only:

☐ Proof of Insurance Provided (if applicable) ☐ Systems ☐ Horizon BCBS

☐ Delta Dental ☐ Eyemed

Insurance Carrier: _____ Date of Hire: _____

Valid Through: _____ Date of Eligibility: _____

Insured's Name: _____ Insurance Effective Date: _____

Company: _____ Salary/Wage: _____