OPEN ENROLLMENT FORM (SUPPORT STAFF) – BENEFIT PERIOD 07/1/2023 – 6/30/2024
WAIVER OF BENEFITS
To be completed only if you wish to waive your medical, prescription, or dental benefits

Employee Name: **EID#:**

I voluntarily elect to waive the insurance coverage(s) as indicated below. I understand that by waiving the insurances checked below I will receive a stipend per the table.

Check the insurance(s) you wish to waive:

- ❑ **Medical**
- ❑ **Prescription Drug**
- ❑ **Dental**

Waiving From:	To:	Monthly Medical only	Yearly Medical only	Monthly Med/Rx	Yearly Med/Rx
Family	Single	$120.00	$1,440.00	$150.00	$1,800.00
Family	Parent/Child	$100.00	$1,200.00	$125.00	$1,500.00
Family	Parent/Children	$80.00	$960.00	$100.00	$1,200.00
Family	No coverage	$200.00	$2,400.00	$250.00	$3,000.00
Employee/Spouse	Single	$80.00	$960.00	$100.00	$1,200.00
Employee/Spouse	No coverage	$160.00	$1,920.00	$200.00	$2,400.00
Parent/Children	No coverage	$120.00	$1,440.00	$150.00	$1,800.00
Parent/Child	No coverage	$100.00	$1,200.00	$125.00	$1,500.00
Single	No coverage	$80.00	$960.00	$85.00	$1,020.00
New Hire under CBA*		$80.00	$960.00	$85.00	$1,020.00
Waiving Prior to CBA*		$80.00	$960.00	$85.00	$1,020.00

*CBA – Collective Bargaining Agreement dated 7/1/2017

If waiving medical coverage: Bargaining Unit Members electing the waiver payment in lieu of the collective coverage shall provide the District with documentation of coverage in a group insurance plan.

Employer Providing Coverage (Name/Address): ______________________________

Name of Insured and Relationship: ______________________________

Insurer/Plan Name/Type: ______________________________ Policy #: ______________

Authorization:

I certify that I have adequate medical coverage elsewhere for myself and my dependents. I agree that if I lose my medical coverage, I will notify the Human Resources office within 30 days from the loss of coverage date and will enroll in a Pennsbury plan. If for any reason, I waive medical coverage and as a result, incur any medical expenses that are uncovered, I recognize that these expenses may be my or my family's personal obligation. I agree that if I have a life event (marriage, death, birth of child, divorce or loss of coverage), I will notify the Pennsbury Human Resources office within 30 days if I wish to change my elections.

______________________________ ______________________________

EMPLOYEE SIGNATURE DATE