

**MONROE COUNTY INTERMEDIATE SCHOOL DISTRICT**

***WAIVER OF HEALTH INSURANCE AND CASH-IN LIEU ELECTION FORM***

***Name***:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ***Date***:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Election or Waiver of Health Coverage**

I elect the following with regard to health coverages made available my Monroe County Intermediate School District based on my job classification and hours:

\_\_\_\_\_\_\_ I **elect** medical coverage. I agree to complete any enrollment forms that are necessary.

\_\_\_\_\_\_\_ I **waive** medical coverage and elect cash-in-lieu of $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/annually

\_\_\_\_\_\_\_ I **elect** dental coverage. I agree to complete any enrollment forms that are necessary.

\_\_\_\_\_\_\_ I **waive** dental coverage and elect cash-in-lieu of $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/annually

\_\_\_\_\_\_\_ I **elect** vision coverage. I agree to complete any enrollment forms that are necessary.

\_\_\_\_\_\_\_ I **waive** vision coverage

If I waive health coverage, I understand that I will receive additional compensation as follows:

* The amount of the additional coverage will be determined under the applicable collective agreement, employee handbook or individual contract.
* The additional compensation will be paid in equal installments as outlined under the applicable collective agreement, employee handbook or individual contract.
* The additional compensation will be subject to all applicable tax withholdings.

**Subsequent Elections**

I understand that my election cannot be changed during the plan year unless I have qualifying change in family or personal status. My next opportunity to enroll myself and/or my dependents will be during the next open enrollment period

***Signature***:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please return this form to:

Janel Faber

Janel.faber@monroeisd.us

Human Resources Department