West Windsor-Plainsboro Regional School District

Health Benefits
321 Village Road East
West Windsor, New Jersey 08550
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Health Insurance Waiver Form

Name: ___________________________________ SSN: ______-____-______ Date of Birth: ___ /__ /______

An annual submission of a health insurance waiver is required to receive waiver incentive payments for the medical, dental, and/or prescription plans**.** A completed hardcopy waiver form and the required documentation is necessary for the initial election to waive any benefits**.** Submit your completed form via email or interoffice mail, **with supporting documentation as indicated below,** to the Health Benefits in Human Resources. Please select each plan that you are waiving and include the level of coverage.

Should you choose to participate in the waiver program and later experience a QLE (qualified life change event), including losing coverage with your alternate carrier, you may enroll in the WW-P health benefits prior to the annual health insurance open enrollment period. In order to do so, you will need to submit your application and loss of coverage notice to the Health Benefits Department within 30 days of the loss of coverage event date.

I hereby elect to waive the insurance plans selected below. Once approved, I understand that I will receive waiver payments based on policy or collective negotiations agreement.

By signing below, I agree to the terms of this document in order to receive waiver payments (if eligible):

- **I must provide a letter from the insurance provider/covering employer OR copy of the insurance card with my name, each benefit listed and insurance start date prior to the waiver start date.**
- **If applicable, a copy of my marriage certificate is required for a spouse and birth certificates are required for child dependents.**
- **I understand lack of proof or supporting documents will result in $0 waiver payment.**
- **Payments are made September through June.**
- **I am not eligible for the prescription waiver incentive if enrolled as a spouse or child dependent under the WW-P prescription plan.**
- **Waiver payments will not be retroactive (paperwork must be submitted no later than the 5th of the month prior to the waiver payment start date).**

Employee's Signature: ____ Sign Date: ____ /____ /____

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Check the eligible plan(s) and one coverage level that you elect to waive

☐ Medical	☐ Prescription	☐ Prescription: Covered under WW-P	☐ Dental
☐ Single	☐ Employee/Spouse	☐ Parent Child/Children	☐ Family

Spouse/Child Dependent Name	Relation	DOB	SSN
		____ /____ /_____	-- --
		____ /____ /_____	-- --
		____ /____ /_____	-- --
		____ /____ /_____	-- --

HR USE ONLY: Date Received_____/______/______

☐ **Provided Proof of Coverage** ☐ **Did Not Provide Proof of Coverage** ☐ **Dependent Proof** **Rev. 6/23**

The mission of the West Windsor-Plainsboro Regional School District, valuing our tradition of excellence, is to develop all of our students as passionate, confident, lifelong learners who have competence and strength of character to realize their aspirations and thoughtfully contribute to a diverse and changing world.