NEWBURGH
ENLARGED CITY SCHOOL DISTRICT

Dr. Roberto Padilla — **Superintendent of Schools**

Mr. Ed Forgit — Deputy Superintendent
Ms. Mary Ellen Leimer — Asst. Superintendent, Human Resources
Ms. Marianne Heslin — Asst. Superintendent, Finance
Ms. Sara Feliz — Asst. Superintendent, Curriculum & Instruction

Memorandum

To: All FT Employees
From: Keisha Martinez, Health Benefits
Date: May 20, 2016
Re: 2016-2017 Health Insurance Buy-Out Forms

Attached please find the 2016-2017 Health Insurance Buy-Out form. Please note that the Health Insurance Buy-Out forms must be completed by anyone wishing to participate in the Health Insurance Buy-Out for the 2016-2017 school year. Buy-Out forms will also be available on the Health Benefits page for download. In order to verify current health insurance coverage, a copy of your current health insurance card must also be submitted with the completed forms. All forms must be returned to the Health Benefits Department by Friday June 17th, 2016.

CONFIDENTIAL

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To: All Full-Time Employees

From: Keisha Martinez, Health Benefits Specialist

RE: Health Insurance Buy-Out 2016-2017

Date: May 20, 2016

If you are eligible to be insured under your working spouse's health insurance plan, you may opt out of the District health insurance effective, September 1, 2016. **Everyone** who participates in the buy-out must submit a new buy-out form each year and provide proof of other health insurance coverage at the time of request. If both spouses are eligible for insurance through the Newburgh Enlarged City School District, only one Buy-Out may be requested.

Buy-Outs are paid each October for the current school year. The Buy-Out for active employees will be paid through payroll at the rate of $800.00 for support staff and $1500.00 for teachers, teaching assistants and administrators. Appropriate deductions will be made. The Buy-Out for retired teachers will be paid the last payroll in October. **Please note: Buy-Outs for new hires are pro-rated.**

During the year, you may resume insurance coverage if necessary. You may re-enter the plan immediately if the reason is due to a qualifying event such as a change in family status or loss of employment. **Otherwise, you must wait three months after you provided notice of your wish to re-enter the District's health insurance plan.** If you are currently participating in the buy-out and wish to re-enter the District's health insurance plan, please contact my office for an insurance enrollment form. You must also submit a letter requesting re entry into the District's health insurance plan. A payroll deduction will be made for each month of the restored coverage to recoup the Buy-Out previously paid. In addition, if your employment should end during the current school year, you are responsible for reimbursing the District a pro-rated amount of the Buy-Out previously paid to you.

If you wish to participate in the Health Insurance Buy-Out for the 2016-2017 school year, please complete the attached form and send a copy of your current health insurance card to the Health Benefits Department at the Board of Education, by June 17, 2016. If you and your spouse will be retiring soon, please remember that the surviving spouse of our employee must pay the full cost of coverage. Therefore, it may be advisable for your spouse to be enrolled in an individual health insurance plan with his/her employer

Please answer each question and return completed form to Health Benefits:

Date: _____

Employee Last Name: _____

Employee First Name: _____

Building Location: _____

Birthday Month _____

Circle one: Administrator Civil Service Man Conf Retiree Teacher Teaching Asst

Name and relationship of Insured Person whose health plan you are listed on as a dependent:

_____

Birthday Month of Insured Person:

_____

Eligible dependent children covered under your health insurance plan:

_____yes no_____

Please list insured person's employer or former employer if retired:

_____

Please list the complete name and address of the health insurance plan you are currently under as a dependent:

_____

_____

Impt: Please provide a copy of your current health insurance card which lists you as a dependent and attach to this form.

DECLINATION OF HEALTH INSURANCE FORM

By signing this form I am electing not to participate in any of the health insurance plans that the District offers. I understand that by declining to enroll at this time:

1. I may subject myself and/or my dependents to certain applicable waiting periods should I decide to enroll at a later date.

Name: _____

Signature:_____

SS Number (Last 4 Numbers) _____

Date:_____