BARNEGAT TOWNSHIP SCHOOL DISTRICT
550 BARNEGAT BOULEVARD NORTH
BARNEGAT, NEW JERSEY 08005
(609) 698-5800 FAX (609) 698-5976

WAIVER OF HEALTH BENEFITS
2024 – 2025 School Year

Under the terms of your contract, if you are covered under another health benefits plan and are eligible for family, 2 adult, parent/children or single level medical, prescription or dental benefits with Barnegat Board of Education, you may elect to waive your health benefits coverage for a cash payment. You can waive all or part of the package. If you elect to make this choice, **you must complete, sign and submit this form waiving your health benefits due to other coverage, along with the Buy Back Participation form, Dependent Information form (if applicable), and copies of proof of all coverages being waived.**

Regardless of past practice, ALL participants in the buyback program are required to complete and submit all applicable forms AND proof of other insurance, *each school year* during open enrollment in order to be eligible for a buyback.

IMPORTANT NOTE: *Barnegat Board of Education does not encourage any employee to receive a cash payment in lieu of adequate health coverage. As such, it is highly recommended that each employee consult with his/her spouse or family prior to making a decision.*

By execution hereof, I represent and acknowledge that I have been offered health benefits coverage through Barnegat Board of Education and I am waiving said health benefits coverage offered, as indicated below and on the participation form, because I have coverage under another health, prescription and/or dental plan. I understand that I may enroll in health benefits through Barnegat Board of Education outside of open enrollment, due to loss of other coverage, and must notify the Benefits department and provide documentation within 31 days of the loss of other coverage.

[ ] By checking this box, I acknowledge I have been offered Health Benefits coverage through Barnegat Board of Education and elect to waive the following checked coverage(s) for the period of the 2024/2025 school year because I am covered under another health benefits insurance policy:

TYPE OF COVERAGE	WAIVED
Medical Coverage	
Prescription Coverage	
Dental Coverage	

_____ _____
PRINT NAME **SCHOOL & DEPT.**

_____ _____
SIGNATURE (in ink) **DATE**

For office use only:
Date of F/T Status_____
Date of Eligibility _____

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HEALTH BENEFITS "BUY-BACK" PARTICIPATION FORM
2024-2025 School Year

Under the terms of your contract, if you are covered under another health benefits plan, and you are eligible for family, 2 adult, parent/children or single level medical, prescription or dental benefits with Barnegat Board of Education, you may elect to waive your health benefits coverage for a cash payment. You can "buy back" all or part of the package. If you elect to make this choice, **you will receive 25% of the annual health benefits premiums (medical, prescription, dental) after what your calculated health benefits payroll contribution would have been is deducted from those premiums. The "buyback" is paid in two installments, December and June.** The total cash payout will not exceed $5,000 annually and is based on a 12-month calculation, paid in two equal installments or pro-rated based on period of eligibility.

Regardless of past practice, ALL participants in the buyback program are required to submit this form, along with the Waiver of Health Benefits, Confidential Request for Dependent Information (if applicable), and proof of other insurance, *each school year* during open enrollment in order to be eligible for a buyback.

In order to participate in this program, you must provide proof of other coverage. Please complete this form and return it to the Benefits department along with copies of proof of other insurance, waiver and dependent information form (if applicable).

Employee buyback amounts are calculated individually based on premium, salary and Chapter 78 percent of contribution.

***IMPORTANT NOTE**: Barnegat Board of Education does not encourage any employee to receive cash in lieu of adequate health coverage. As such, it is highly recommended that each employee consult with his/her spouse or family prior to making a decision.*

By execution hereof, I represent and acknowledge my choice to waive the following health benefits coverage(s) because I have coverage under another health, prescription and/or dental plan.

I elect to "buy back" the following benefits as indicated below for the period of the 2024/2025 school year (please check all that apply based on your eligibility):

Single	2Adults	Parent/Children	Family
( ) Medical	( ) Medical	( ) Medical	( ) Medical
( ) Prescription	( ) Prescription	( ) Prescription	( ) Prescription
( ) Dental	( ) Dental	( ) Dental	( ) Dental

_____ _____
PRINT NAME **SCHOOL & DEPT.**

_____ _____
SIGNATURE (in ink) **DATE**

For office use only:
Date of F/T Status_____
Date of Eligibility _____
Medical Plan Eligible:_____

Entered in: Systems 3000_____BB Spreadsheet_____
Calculated Salary_____Number of Pays_____

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CONFIDENTIAL REQUEST FOR DEPENDENT INFORMATION
2024/2025 School Year

Employee Name _____

Title/Position _____

School/Dept. _____

All employees who participate in the insurance buyback program, and are eligible for dependent level coverage, must provide the following dependent information, **including spouse** if applicable:

DEPENDENT	RELATIONSHIP	DATE OF BIRTH	SOCIAL SECURITY NUMBER