

**SACHEM CENTRAL SCHOOL DISTRICT AT HOLBROOK**  
**WAIVER OF HEALTH INSURANCE**

I wish to exercise my option to opt out of and not participate in the health insurance program.

By my signing this waiver, I understand that I will be giving up my right, as an employee of the Sachem Central School District, to be covered by the District's health insurance program and any benefits provided by the program for the period covering the balance of the current calendar year. I shall receive from the District a cash payment equal to one-half (1/2) of the premium that the District will not have to pay for my health insurance for the balance of the current calendar year. Such amount will be paid to me during the months of June and December if applicable.

I further understand that I may revoke this waiver and be re-enrolled in the District's health insurance program, effective January 1 of any year, without any waiting period, by giving written notice to the Assistant Superintendent for Personnel at least thirty (30) days prior to my re-enrollment (January 1).

If at any time during the period when this waiver is effective it becomes necessary to re-enroll in the District's health insurance plan due to loss of coverage under another plan (COBRA rights notwithstanding), the District shall permit the re-enrollment without a waiting period, if written proof of loss of coverage under another plan is submitted. In the event, however, that I opt out and I was not covered by another health program and it becomes necessary to re-enroll in the District's health program, I understand that my coverage under the District's health insurance program will not become effective until three (3) months after I re-enroll.

I hereby release the union which represents me and the Sachem Central School District, their employees and agents from all actions, suits, debts, judgments, claims, and demands whatsoever in law or equity arising out of or concerning any elect not to participate in the District's health insurance program, in accordance with the terms of this Agreement.

I make this waiver of benefits without duress and/or coercion of any form and in full knowledge of its consequences.

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\_\_\_\_\_ Yes, I am interested in the Health Insurance Waiver. If applicable, please cancel my health insurance and discontinue my premium contribution. Opt Out eligibility is effective only for the months that the employee is eligible for health insurance; enrollment will begin when all applicable paperwork is received and processed by the District.

If you do not return this form, it is assumed that you do not wish to opt out of the health insurance for the balance of the current calendar year.

Withdrawal: (check one)      Individual \_\_\_\_\_      Family\*\* \_\_\_\_\_  
(provide copy of health insurance card)      (provide copy of health insurance card and marriage certificate)

Social Security Number \_\_\_\_\_ Date \_\_\_\_\_

Name \_\_\_\_\_ Signature \_\_\_\_\_  
(please print)

\_\_\_\_\_  
Signature – District Representative

\*\*Employees opting out for family coverage need to submit a copy of their marriage certificate.