Poughkeepsie City School District

18 S. Perry St. Poughkeepsie, NY 12603

DATE: May 1, 2024

TO: All employees (active or retired) eligible for health insurance

FROM: Ken Silver, Assistant Superintendent for Business

RE: 2024-2025 Health Insurance Opt-Out

Due Date: May 31, 2024

Any employee (active or retired) eligible for health insurance who elects to not receive coverage from the district for the 2024-2025 school year **is required** to complete the attached forms, *providing proof of alternate coverage*, and return to Benefits, in the **Business Office**.

Any opt-out amounts are based on the employee's respective collective bargaining agreement or non-Represented employee's policy, as applicable, and are fully taxable.

The following documentation is required:

1) Health Insurance Opt-Out – Cover Page

2) Health Insurance Opt-Out – Waiver of Coverage

3) Health Insurance Opt-Out – Proof of Coverage/Affidavit Attach a photocopy of insurance card for alternate insurance, **AND** Either:

ii. Sign **and have NOTARIZED** the affidavit, **OR**

iii. Attach letter from employer of your spouse/partner/parent stating that you are covered under their health insurance plan

Please direct any questions to Tamisha Greenhill, tgreenhill@poughkeepsieschools.org or 845-451-4900 x.4963

Forms received after May 31, 2024 will only be accepted for new hires/for qualifying events.

**********ANNUAL**********

Poughkeepsie City School District

2024-2025 Health Insurance Opt-Out

Cover Page

For Employee

Please complete

Items 1-9

1. Name: _____

2. Employee ID Number: _____

3. Address: _____

4. City, State: _____

5. Zip code: _____

6. Building: _____

7. Union/Unit: _____

8. Active ☐ Retired ☐

9. Date Filed: _____

(*For Business Office*)

Proof of insurance on file: Yes_____No_____

Amount to pay: $_____

Authorization to pay opt-out:

_____

*********ANNUAL**********

Poughkeepsie City School District

2024-2025 Health Insurance Opt-Out

Waiver of Coverage

I_____ hereby elect not to receive Health Insurance provided by the district in lieu of the opt-out of the health insurance program provided by the Poughkeepsie City School District for the 2024-2025 school year. I understand that the above election will remain in effect until the last day of the Period of Coverage noted previously. I understand that by participating in the opt-out program, I will receive payment through payroll for the amount stated in my contract agreement or non-Represented policy.

I understand that the only time that I may be permitted to opt back into the health insurance program is during the annual open enrollment period, or if I should experience a Qualifying Life Event (QLE), as defined under applicable law. QLE's include a change in your legal marital status, birth or date you adopt a child, death of a spouse or dependent, or loss of employment. Finally, I understand that the election noted above may need to be modified by the district to ensure that the Plan complies with applicable tax rules.

_____ _____

Date Signature of Participant

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Poughkeepsie City School District

2024-2025 Health Insurance Opt-Out

Proof of Coverage/Affidavit

I_____hereby certify that I am covered under the_____health insurance plan as evidenced by the attached photocopy of my insurance card.

_____ _____

Signature Date

Acknowledgement to be completed by Notary Public

STATE OF NEW YORK, COUNTY OF DUTCHESS

On this_____day of_____20_____ before me personally appeared_____to me known and known to be the person described in and who executed the foregoing instrument, and he/she duly acknowledged to me that he/she executed same.

Notary Public: _____ _____

Signature Stamp Including Expiration date