Poughkeepsie City School District

18 S. Perry St. Poughkeepsie, NY 12603

DATE: May 15, 2023

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

FROM: Ms. Louise M. Lynch – Assistant Superintendent for Business

RE: 2023-2024 Health Insurance Opt-Out / Buy-Out,

Due Date: June 19, 2023

Any employee (active **or retired**) eligible for health insurance who elects to not receive coverage from the district for the 2023-2024 school year **is required** to complete the attached forms, *providing proof of alternate coverage*, and return to Benefits, in the **Business Office**.

Any buy-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) 2023-2024 Health Insurance Opt-Out – Cover Page (fill out top section)

2) 2023-2024 Health Insurance Opt-Out – Letter of Intent (sign/date)

3) 2023-2024 Health Insurance Opt-Out – Waiver of Coverage (check the box and sign/date)

4) 2023-2024 Health Insurance Opt-Out – Proof of Alternate Coverage

Attach photocopy of insurance card for alternate insurance, **AND**

Either:

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

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

Please submit all forms and direct any questions to Karen Wright, Junior Accountant, kwright@poughkeepsieschools.org (*preferred*) or 845-451-4900 ext 4961

Forms received after June 19, 2023 will only be accepted for new hires/for qualifying events.

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

Poughkeepsie City School District 2023-2024 Health Insurance

Opt-Out *Cover Page*

For Employee

PLEASE COMPLETE

ITEMS 1-8

1. NAME: _____

2. ADDRESS:_____

3. CITY, STATE:_____

4. ZIP CODE:_____

5. BUILDING:_____

6. UNIT: Administrator_____Cafeteria_____Clerical_____Maintenance_____
Paraprofessional_____Teacher_____Non-Represented_____Security_____

7. Active _____Retired_____

8. DATE FILED:_____

_____

(*For Benefits Administrator*)

Proof of insurance on file: Yes_____No_____

Amount to pay: $_____

_____

(For Business Office approval)

Authorization to pay buy-out:

_____

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

Poughkeepsie City School District 2023-2024

Health Insurance Opt-Out

Letter of Intent

I _____wish to opt-out of the health insurance program provided by the Poughkeepsie City School District for the 2023-2024 school year. I understand that by participating in the opt-out program, I will receive a cash buy-out 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 have a qualifying life event.

_____

Signature

_____

Date

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

Poughkeepsie City School District

2023-2024 Health Insurance Opt-

Out *Waiver of Coverage*

NAME (print):_____EMPLOYEE # _____

ADDRESS: _____

_____

HEALTH INSURANCE WAIVER

I hereby elect not to receive Health Insurance provided by the District, July 1, 2023 through June 30, 2024, instead to receive the Benefit Credit as the District will make available to me in cash.

I understand that the above election will remain in effect until the last day of the Period of Coverage noted above. I understand that I may change the above elections during the Period of Coverage noted above only if I experience a "Qualifying Life Event", as defined under applicable law, and I may change my elections only in a manner consistent with that "Qualifying Life Event". Elections are irrevocable unless you experience a Qualifying Life Event. QLEs 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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**********ANNUAL**********

Poughkeepsie City School District

2023-2024 Health Insurance Opt-Out

Proof of Alternate Coverage

REQUIRED PROOF – CHECK ALL THAT APPLY:

Photocopy of insurance card - attached (REQUIRED EACH YEAR)

Letter from other employer providing alternate health insurance 7/1/23 – 6/30/24 attached, **OR**

If letter from other employer, as noted above, will not be obtained, the following steps are **required**:

Affidavit signed below, **AND** Notarized below

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

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