

Poughkeepsie City School District

18 S. Perry St. Poughkeepsie, NY 12603

DATE: May 20, 2022

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

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

RE: 2022-2023 Health Insurance Opt-Out / Buy-Out,

Due Date: June 24, 2022

Any employee (active **or retired**) eligible for health insurance who elects to not receive coverage from the district for the 2022-2023 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) 2022-2023 Health Insurance Opt-Out – Cover Page (fill out top section)
- 2) 2022-2023 Health Insurance Opt-Out – Letter of Intent (sign/date)
- 3) 2022-2023 Health Insurance Opt-Out – Waiver of Coverage (check the box and sign/date)
- 4) 2022-2023 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 845-867-6103

Forms received after June 24, 2022 will only be accepted for new hires/for qualifying events.

**Poughkeepsie City School District 2022-2023 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 Assistant Superintendent for Finance and Operations)

Authorization to pay buy-out:

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Poughkeepsie City School District 2022-2023
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 2022-2023 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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**Poughkeepsie City School District
2022-2023 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, 2022 through June 30, 2023, 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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**Poughkeepsie City School District
2022-2023 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 7/1/22 – 6/30/23 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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