NESHAMINY SCHOOL DISTRICT
2016-17 PROOF OF OTHER HEALTHCARE COVERAGE FOR OPT OUT PURPOSES

The Neshaminy School District provides health and prescription coverage for full-time employees of the district. Individual employees can opt out of coverage if they have coverage from another source. The district requires proof of other coverage for those who elect to opt out. Some groups are eligible for payment in lieu of medical and prescription coverage. Please see your group's contract for specific information. All agreements are available on the district website.

TERM OF ELECTION AND MID-YEAR CHANGES – IRS SECTION 125 REQUIREMENTS

The District has instituted a Section 125 plan with the Internal Revenue Service in order to facilitate pre-tax contributions and opt-out distributions. The Internal Revenue Service has specific guidelines for Section 125 plans. One of the guidelines is in regard to when you can make changes to your plan election. Under Section 125 you are only able to make changes during the designated open enrollment period (effective July 1, 2016) or when you experience a "life event". Life events are defined as the following: termination of employment, reduction of hours in employment, birth or adoption of a child, loss of alternative health coverage, death of an immediate family member; marriage; or divorce. **Benefit options selected during open enrollment are effective for the full year (July 1 to June 30) unless you experience a "life event".**

EMPLOYEE ELECTION AND DISCLAIMER

If choosing to elect health and prescription benefits you just need to complete the online selection from the Employee Access Center. The attached form is only needed if you are declining health and/or prescription coverage with the district. If you are opting out of the coverage you are acknowledging that you and all eligible members of your family have been given the opportunity to become a participant in the District's health benefit program. You waive and disclaim any right you, your spouse and/or dependents have to participate in the health plan or receive health benefits from the District, your employee group or union or their agents and successors. In waiving health benefits, you understand that you and your family will not again become eligible to participate until the next open enrollment period, or if earlier, experience a life event as listed above.

If you currently have benefits and do not complete this form, your benefits and deductions will continue effective July 1, 2016.

Note: No employee shall be covered as a subscriber to any to any District health, prescription, dental or vision plan and also be covered as a dependent under that plan or any other district plan. An employee who is covered by any district plan is not eligible for opt out payment (if available).

EMPLOYEE SECTION: Name: _____ (Print)

I wish to waive the following coverage: Medical _____ Prescription _____ Dental _____ Vision _____

The following is the information regarding my alternative coverage and I have attached proof of coverage (i.e. letter from alternative coverage and/or insurance card(s).

Coverage Type: _____

Carrier: _____ ID #: _____

Subscriber Name: _____

Effective Date: _____ Relationship to Subscriber: _____

Source of Coverage: (Employer name/Individual coverage): _____

Signature: _____ Date: _____