Franklin County District Schools

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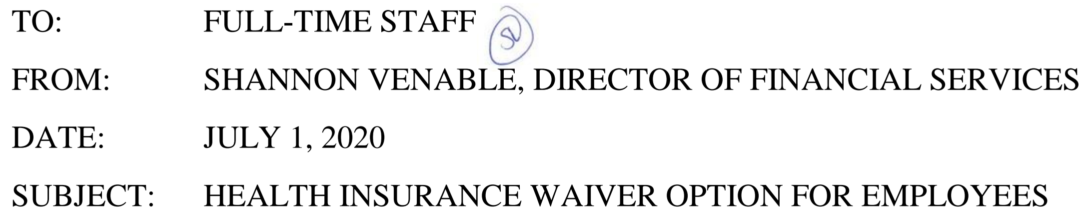

TO: FULL-TIME STAFF

FROM: SHANNON VENABLE, DIRECTOR OF FINANCIAL SERVICES

DATE: JULY 1, 2020

SUBJECT: HEALTH INSURANCE WAIVER OPTION FOR EMPLOYEES

JULY 1, 2020 THROUGH JUNE 30, 2021

Franklin County School Board is now offering a Health Insurance Waiver option for active full-time employees. The requirements of federal law do not allow the School Board to offer this option to employees covered by Medicare [See 42 USC 1395y(b)(3)(c)]. Eligible employees who have proof of other qualifying health coverage may opt out of the School Board's group health plan and receive $2,500.00 annually in 24 semi-monthly payments on a pro-rata basis for the period of waived coverage.

The $104.16 semi-monthly wavier supplement (or $208.32/month) will be treated as taxable income. This is effective for the remainder of this plan year and is subject to review each year.

Along with your proof of coverage, complete and return the attached forms to Ally Millender for qualification.

1) HealthPlan Waiver Application
2) Proof of coverage of Health Insurance

If you have any questions in regards to this waiver, please call (850) 670-2810 Ext. 4138.

FRANKLIN COUNTY SCHOOL BOARD
HEALTHPLAN WAIVER APPLICATION & REQUIREMENTS

The Franklin County School Board is offering an alternative option for active full-time employees not covered by Medicare **who have proof of other qualifying health coverage.** Employees may opt out of the School Board's health plan and receive $2,500.00 annually in 24 semi-monthly payments on a pro-rata basis for the period of waived coverage. This is effective for the 2020-21 Plan Year and is subject to review each year.

In order to be qualified for this option, you must satisfy the following conditions and make the following acknowledgements:

_______ I understand and acknowledge that I am required to show proof of acceptable medical coverage in order to waive coverage. Other qualifying health coverage includes other group coverage. (A copy of the ID card or Certificate of Coverage must be attached to this waiver)

_______ I understand and acknowledge that I am responsible for determining that my other qualifying coverage is comprehensive.

_______ I understand and acknowledge that coverage must be waived for myself and for my dependents and that by exercising this election to waive coverage that I and my dependents will receive no benefits under the School Board's health plan.

_______ I understand and acknowledge that if I wish to enroll in the School Board's health plan at a later date, I will be subject to the plans enrollment rules, including any re-enrollment or waiting periods, pre-existing condition clauses, and medical underwriting clauses.

_______ I understand and acknowledge by electing to waive coverage that I will not be able to elect medical coverage under COBRA under the School Board's health plan.

_______ I understand and acknowledge that the waiver supplement is subject to payroll tax.

_______ I am returning a completed Employee Benefit Election Summary Form and Health Change Application.

I have read and understand the above, and I understand that the School Board accepts no responsibility for liability that results as a consequence of this decision. I accept the consequences of this election and have received a copy of this wavier.

____ ____
Signed Witnessed

____ ____
Printed Name Date