Bellmore-Merrick CHSD
Office of Personnel & Administration

MEMORANDUM

To: All Eligible Employees

From: Dr. Mara Bollettieri
Assistant Superintendent for Personnel and Administration

Re: Declination of Health Insurance/Opt out

Date: Open Enrollment 2014

According to your Unit Contract, if you choose NOT to participate in the District's health insurance and go on the buyout you must complete the following forms:

-Declination of Health Insurance
-AHCA Waiver

Please complete the appropriate section of the Declination of Health Insurance Form:

SECTION A

The HIP Declination Section A, is ONLY completed if you are covered under NYSHIP (Empire).

SECTION B

If you have coverage other than NYSHIP (Empire) you will complete Section B, the New York Health Insurance Program NYSHIP-Empire.

In addition, regardless of the coverage you have, you **MUST ALSO** complete the AHCA Waiver in addition to the declination form.

Lastly, please do not forget to send in a copy of your health insurance card.

If you have any questions please feel free to call the Personnel Office at x1013

Thank you.

MB/rj

Bellmore-Merrick CHSD
Office of Personnel & Administration

DECLINATION OF BENEFITS FORM

Employee Name: _____

Unit/Job Title: _____

Building: _____

If you wish to decline health insurance coverage please complete either section A or B and you **MUST** complete the reverse side of this form regardless of what health insurance you have.

SECTION A:

TO BE COMPLETED ONLY IF YOU ARE COVERED UNDER A NYSHIP-EMPIRE PLAN

DECLINATION OF HEALTH INSURANCE (HIP/HMO)

At this time, I do not want to enroll in the HIP/HMO plan offered by the District. I understand that by declining to enroll at this time:

I may subject myself and/or my eligible dependents to certain applicable waiting periods if I decide to enroll at a later date.

I may be forfeiting the right to such coverage after my retirement.

Name (Please Print)	Social Security Number
Signature	Date

SECTION B:

TO BE COMPLETED ONLY IF YOU ARE COVERED UNDER ANY OTHER HEALTH INSURANCE PLAN OTHER THAN NYSHIP-EMPIRE

DECLINATION OF HEALTH INSURANCE
(NEW YORK HEALTH INSURANCE PROGRAM-NYSHIP-EMPIRE)

At this time, I do not want to enroll under any option of the New York State Health Insurance Program. I understand that by declining to enroll at this time:

I may subject myself and/or my eligible dependents to certain applicable waiting periods if I decide to enroll at a later date.

I may be forfeiting the right to such coverage after my retirement.

Name (Please Print)	Social Security Number
Signature	Date

AHCA page must be completed if waiving Health Insurance offered by the District.
Be sure to submit a copy of your health insurance card along with this form.

Turn over ⇨

Bellmore-Merrick CHSD
Office of Personnel & Administration

AFFORDABLE HEALTH CARE ACT (AHCA) WAIVER

Employee Name: _____

Date: _____

Plan Year: _____

Please Check ONE:	
☐	**I waive enrollment in my employer's group health insurance plan for myself**
☐	**I waive enrollment in my employer's group health insurance plan for myself AND my dependents**
☐	**I am enrolling in my employer's group health insurance plan for myself but I am waiving coverage for my dependents**

Reason for Waiving- Please check ONE:	
☐	**I am covered through my spouse's employer OR**
☐	**I am covered through my former employer's retiree health insurance plan OR**
☐	**I am covered through a parent's employer OR**
☐	**Other. Please Explain:**_____

PLEASE SUBMIT PROOF OF COVERAGE

I understand that I am waiving coverage from my employer that is offering me health insurance* (NYSHIP/*EMPIRE, and HIP/HMO).

Employee Signature: _____ **Date:** _____

Employer Signature: _____ **Date:** _____

Personnel Office Use Only			
Proof of Coverage:			
Received by:		**Date:**	

AHCA page must be completed if waiving Health Insurance offered by the District.
Be sure to submit a copy of your health insurance card along with this form.

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