



TOMS RIVER REGIONAL SCHOOLS BOARD OF EDUCATION

1144 Hooper Avenue
Toms River, New Jersey 08753
(732) 505-5500

Michael Citta
Superintendent of Schools

William J. Doering
Business Administrator

HEALTH INSURANCE WAIVER FORM

I hereby waive health insurance benefits (in which I am currently enrolled/eligible) with the Toms River Regional Schools Board of Education. I understand that this includes medical, prescription, dental and vision coverage. I hereby certify that I am actively enrolled in another plan. I have completed the information below and **attached a copy of the identification card(s) for such alternate plan.**

I understand that I will be compensated \$2,500 per school year for such waiver: \$1,250 with the second pay period in July (to cover the prior period from January 1st through June 30th) and \$1,250 with the second pay period in January (to cover the prior period July 1st through December 31st).

I also understand that I may only re-enroll into any eligible coverage during an Open Enrollment period, or upon proof of any qualifying event as defined by the health insurance provider.

Employee Name _____ DOB _____
(Last) (First) (MI)

Home Address _____ Home Number _____
_____ Cell Number _____

Personal Email Address _____ School/Work Location _____

Effective Date of Waiver _____

Current Coverage Is With: TRRS* Spouse Other _____

Contract Type: Single Emp/Spouse Emp/Child(ren) Family

***Please complete the following only if Current Coverage is through the TRRS. List all Persons Covered:**

Name (Last, First, MI)	Relation (Spouse/Child)	Gender (M or F)	DOB (Mo/Day/Year)

I certify that the information presented on this form is true and correct.

Employee Name (Print) _____

Employee Signature _____

Date _____

Office Use Only:
Rec'd by TRBOE _____ Added to Spreadsheet _____ Payroll Notified _____ Bargaining Unit _____