# LINDEN PUBLIC SCHOOLS

## Business Office

**Atiya Y. Perkins**
Superintendent of Schools

**John A. Serapiglia, Jr.**
Business Administrator/Board Secretary

**Administration Building**
2 E. Gibbons Street
Linden, NJ 07036
(908) 486-2800 Ext. 8015
FAX (908) 486-8891

## 2024-2025 EMPLOYEE HEALTH INSURANCE COVERAGE WAIVER

**Part 1: To be completed by employee**

**Employee Name**_____**SS#** _____

In accordance with Chapter 92, P.L. 2007 and Chapter 2, P.L. 2010, I have agreed to waive coverage (medical and prescription drug coverage) with the Linden Board of Education to which I am entitled because I am covered under other health coverage. (Employees who waive medical/rx can still enroll in dental).

- If I am determined to be eligible for the waiver payment, my employer will pay me an amount based on 25% of the amount saved by the employer, not to exceed $5,000, whichever is less. This is in lieu of providing Insurance coverage *(payments are processed in the last payroll of the school year in June).*
- I understand that I may resume the Linden Board of Education health coverage when I am no longer covered by the other health coverage, provided that I notify the Benefits Office (Taryn Ragonese-Carlson) within 60 days of the loss of the other coverage and provide proof of loss of that coverage.

---

*Note: You must submit proof of other coverage by providing a copy of your current insurance ID card to the Benefits Office, along with this form. If this is your initial eligibility to enroll or waive, we require supporting documentation for waiver of dependent coverage levels. For waiver of 2 adults coverage, please provide a copy of your marriage certificate/civil union; for waiver of family coverage, please provide both marriage and birth certificate(s).*

---

**The deadline for submitting the waiver paperwork and proof of private coverage is *MAY 16, 2025.***
This waiver request must be completed every year. If your other health coverage changes during the year, you must provide a new copy of the other coverage ID card. You will only be notified if you are determined ineligible for the reimbursement.

**Please complete the below information.**

| | |
|---|---|
| INSURANCE CARRIER: | POLICY ID#: |
| COVERAGE PROVIDED THROUGH SPOUSE | ☐ 2 Adults ☐ Family |
| COVERAGE PROVIDED THROUGH PARENT | ☐ Single |

**Employee's Signature**_____ **Date** _____ **Location** _____

**Part 2: To be completed by the employer (FOR BUSINESS OFFICE USE ONLY)**

☐ We will pay the above employee a reimbursement for their health insurance waiver, an amount based on 25% of the amount saved by the employer, not to exceed $5,000, whichever is less. This is in lieu of providing insurance coverage (payments are processed at the end of the school year).

☐ Employee is ineligible for waiver incentive.

_____ _____
**Approval Signature of Business Administrator/ Board Secretary** **Date**

NOTES: