

Scotia-Glenville Central School District
Scotia, NY 12302

**HEALTH INSURANCE DECLINATION
2020-2021 School Year**

Complete this form every year during open enrollment if you are not enrolling in the district's health insurance plans.

Proof of other health insurance must be provided

I decline participation in the Medical Insurance plans offered by Scotia-Glenville Central School District. Other coverage is provided for me under a (check one) _____ family plan or _____ individual plan through (check one) _____ spousal coverage, _____ governmental coverage _____ parental coverage, or _____ other (please specify) _____.

In lieu of the health insurance benefits, the District will pay eligible employees a \$1200 or \$600 stipend in accordance with the applicable contract. (Part-time employees covered under the Local 766 contract will receive a pro-rata portion of the stipend based on their FTE.) The stipend will be paid with the final paycheck in June of the school year constituting **one full year of non-participation**.

___ I have enclosed proof of my health insurance coverage for family plan;

___ I have enclosed proof of my health insurance coverage for individual coverage;

___ My spouse _____ (name) is an employee of Scotia-Glenville and I am covered under a family plan.

(Note: Stipend amount will be paid based on the proof of insurance provided. If proof of individual coverage is provided, stipend will be \$600 or prorated amount for Local 766.

If proof of family coverage is provided, stipend will be \$1200 or prorated amount for Local 766 employees.) **Please ensure the correct proof of coverage is provided to ensure you receive correct stipend you have selected.**

*****If no proof of health coverage is provided, a stipend cannot be paid/will be withheld.

Employee Name (please print)

Date

Signature

- ___ Administrator
- ___ Teacher
- ___ Teaching Assistant
- ___ Local 766
- ___ Clerical
- ___ Aide / Monitor

Stipend Amount _____

____Mgt/Confidential