Scotia-Glenville Central School District
Scotia, NY 12302

HEALTH INSURANCE DECLINATION
2025-2026 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 $1,200 or $600 stipend in accordance with the applicable contract. 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. If proof of family coverage is provided, stipend will be $1,200.00.
Please ensure the correct proof of coverage is provided to ensure you receive the 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 Stipend amount: ____

____Teacher
____ Teaching Assistant
____ Local 766
____ Clerical
____ Aide & Monitor
____Management Confidential