

HEALTH INSURANCE DECLINATION 2026-2027 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 _____ individual plan _____ 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 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

_____ Local 766 _____ Teaching Assistant _____ Clerical

_____ Management Confidential _____ Aide & Monitor

*Please return this during open enrollment to qualify.