WILLOUGHBY-EASTLAKE CITY SCHOOL DISTRICT
CAFETERIA PLAN
Waiver of Group Health Insurance Agreement

As a participant in the Cafeteria Plan of the Willoughby-Eastlake City School District, I hereby voluntarily waive coverage for myself, and/or all of my dependent children under the medical, prescription, dental and vision plans (Benefit Plans) of the School District for the period from July 1, 2020 through June 30, 2021.

I certify that I am covered by the following health insurance program:

_____

Print Name and Group Number of Health Care Plan

In connection with my waiver of Benefit Plan coverage, I hereby acknowledge and agree to the following:

- By making this election, I will be entitled to receive a cash payment of $4,000 paid out in equal **monthly installments** the first pay period of each month.
- Neither me, nor my dependents, will be entitled to receive any reimbursement or payments from the School District or any provider under any of the Benefit Plans, for any type of health care expenses or bills of me or my family that are incurred while this waiver of Benefit Plan coverage is in effect.
- I can only revoke this waiver of coverage if I am permitted to do so in accordance with the terms of the Cafeteria Plan; and if I am permitted to revoke this waiver of coverage, my ability to elect coverage under any of the Benefits Plans will only be permitted to the extent that it is allowable to do so under the terms and conditions of the Benefit Plans.
- If I do revoke this waiver of coverage, I am responsible for reimbursing the Board of Education for any excess payment that I have received. Reimbursement would be handled through a payroll deduction.
- All cash payments I receive as a result of my waiver of Benefit Plan coverage are subject to Federal, State and City tax deductions, as well as the federal Medicare tax (if it applies to me).

Printed Name: _____

Employee Signature: _____

Employee Number: _____

Date: _____

Location/Position: _____