BUFFALO CITY SCHOOL DISTRICT
WAIVER INCENTIVE PROGRAM

I hereby elect to waive my rights to District paid health insurance coverage, and to receive instead additional compensation in the amount of $100 per month (maximum payment of $1,200 per year) for pool and $250 per month (maximum payment of $3,000) for incentive. I understand that it is my sole responsibility to evaluate the advantages and/or disadvantages of electing to waive my health insurance coverage, and to decide whether or not to exercise this waiver option. I will hold harmless the Buffalo Board of Education and its employees, Unions, agents or representatives, from any causes of action, claim, loss or damage incurred as a result of exercising this waiver of health insurance coverage.

Signature: _____ Date: _____

Check One:

- ☐ Spouse employed by Board of Education
- ☐ Spouse NOT employed by Board of Education*
- ☐ Not applicable – Single*

Print Name: _____ Social Security #: _____

Address: _____ City: _____ Zip: _____

***COPY OF INSURANCE CARD MUST BE ATTACHED.**

Insured's Name: _____ Insured's SS #: _____

Relation to Employee: _____ Insurance Carrier: _____

ID#: _____ Plan #: _____

EFFECTIVE DATE: the first day of the month following receipt of this enrollment form, including all supporting documentation by the Benefits Office.

PLEASE NOTE:

- An acknowledgement will be mailed to you, along with a copy of your application. Please retain this documentation as your receipt.
- Payments will be issued the second pay period in January of each calendar year based on the number of months of participation in the previous calendar year and are subject to all federal and state withholding, employment and payroll tax provisions.
- Upon request, you may revoke this election and opt for health insurance coverage, effective the first of the following month, after receipt of the completed health insurance application.

For Office Use Only

Union: ☐ Incentive ☐ Pool

Date received:

Date effective: **(Based on hire date and DATE RECEIVED)**

New ☐ **From Insurance Plan** _____ **(cancellation attached)**

Signature:

Email: Benefits@buffaloschools.org