Wachusett Regional School District

Holden, Paxton, Princeton, Rutland, Sterling

WACHUSETT REGIONAL SCHOOL DISTRICT
HEALTH INSURANCE BUY OUT OPTION AGREEMENT
PLAN YEAR 2024 – 2025

I, _____ of _____, a
Name Address

Wachusett Regional School District Employee/Non-Medicare Retiree, am currently enrolled in the District's health insurance. In consideration for the sum of $2000 for family coverage and $1000 for individual coverage. I do hereby cancel my health insurance coverage for my (self) (family). I understand that my cancellation of coverage in whole or in part, shall be for the period of July 1, 2024 to June 30, 2025. I understand that these payments will cease after fiscal year 2025. I understand that I may not request reinstatement of coverage for fiscal year 2025 except in the event of an emergency caused by the loss of health insurance coverage through another source, as described below. Verification of this loss of coverage is required by the School District. Reinstatement of coverage for the succeeding year shall be made in writing to the District no later than April 1 to be effective July 1 of the succeeding fiscal year.
Any employee who previously opted out of the District's insurance under the prior PEC Memorandum of Agreement 2023-2024 who is still opting out of the insurance will continue to receive the opt-out payment in accordance with the payout procedures enumerated as stated above.

I further understand that the consideration payment to me shall be subject to all usual payroll deductions and shall be paid in 2 installments, one in September and one in February of the year for which the election is made or 2 and 6 months after a pro-rated termination of coverage. If reinstatement to health insurance coverage occurs during the waived year due to emergency, or I cease to be eligible for health insurance coverage, by termination of employment or other reason, I agree to repay to the District, pro rata, any amount already paid to me as an unused portion of this agreement within thirty days of reinstatement and/or termination of employment.

I understand that:

- Prior to the first day of each plan year, I will be required to complete a new benefit Election Form. My election is effective for the plan year and may be changed during the year only for changes in family status (e.g.,) (marriage or divorce, death of spouse or dependent, adoption or birth of child, or certain changes in spouse's employment that affect health coverage) that cause the loss of health insurance.

Health Insurance Declination Cash

In accordance with my rights under the plan and this agreement, I elect cash payment for reducing or withdrawing from health coverage as follows (select one):

_____ Family coverage to no coverage _____ Individual coverage to no coverage

_____ _____
Employee/Non-Medicare Retiree Signature Date

Accepted and agreed to by:

_____ _____
District's Authorized Representative Date

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