BENEFITS DEPT.
CAO

HEALTH INSURANCE - EMPLOYEES BUY-OUT NOTICE

If you are eligible for health insurance and are interested in taking advantage of the Health Insurance Declination/Buy-Out Program for the 2024 - 2025 school year, the Benefits Department **MUST** receive your Buy-Out Election Form **and** proof of other health insurance coverage by **April 30, 2024.** You must be eligible for health insurance in order to take advantage of the Buy-Out.

Even if you are a current participant in the Buy-Out Program, a *new* Declination/Buy-Out Form must be submitted each year, along with a copy of your current health insurance card.

Complete the attached form in six (6) places and attach a copy of your current insurance card and inter-mail to the Benefits Dept. at CAO.

If you are interested in enrolling in a health insurance plan, all the information is on our District website Dept./Human Resources/Benefit Plans.

Any question please contact Debbie Bungartz at dbungartz@acsdny.org or (845) 486-4460 ext. 20153.

ARLINGTON CENTRAL SCHOOL DISTRICT
HEALTH INSURANCE/BUY-OUT PROCEDURES
(For Non-Units, Non-Unit ADM, Cabinet, Nurses and Therapists)

May 1st of each year is the general period for employees to opt out of a health insurance plan in exchange for a Buy-Out. Employees eligible for health insurance benefits must inform the Benefits Department at the Central Office by May 1st of their decision to opt out of the District's health insurance plan effective July 1st. Proof of alternate health insurance coverage must also be provided.

If a continuing employee becomes eligible for coverage outside the District (i.e. spouse's coverage), he/she may opt out of the District's health insurance plan at such time that they can present to the benefits department proof of alternate health insurance coverage and provide a signed application.

New employees and continuing employees, who first become eligible for insurance benefits after the general Buy-Out period of May 1st, may opt out of the District's health insurance plan at such time that they can present to the Benefits Department proof of alternate health insurance coverage and provide a signed application.

Employees who inform the benefits department of their decision to opt out of the health insurance program on or before May 1st of each school year will receive the Buy-Out payment on or before October 15th. Employees who opt out at a time other than May 1st of each year will receive payment four (4) months after such proof noted above is provided and a signed application is provided. Payment will be prorated based on the number of months that the District's health insurance plan is waived.

Employees continuing in the Buy-Out Program **MUST** complete and submit a **new** Declination of Health Insurance/Buy-Out Form along with proof of other insurance **EACH** year.

If employment is terminated prior to the payment date, a prorated payment will be made based on the number of months the employee was eligible for health insurance coverage. If the employee receives full payment and subsequently leaves the District's employ before the end of the school year (or loses eligibility for health insurance benefits), they are responsible for paying back to the District the portion of the Buy-Out amount for which they are no longer eligible.

The employee may re-enroll into any health plan only during the annual Open Enrollment Period or if there has been a loss of the alternate health insurance coverage. Re-entry into any health plan shall be conditional upon repaying, on a prorated basis, 1/12th (1/10th for SCHOOL LUNCH) of the Buy-Out prior to the date health insurance would become effective.

I HAVE READ AND UNDERSTAND THESE PROCEDURES.

X _____ SIGNATURE

X _____ DATE

DECLINATION OF HEALTH INSURANCE/BUY-OUT

I acknowledge that the ACSD has made an offer of ACA minimum value affordable health insurance coverage. I do not want to enroll, at this time, under any Health Insurance Plan offered by the Arlington Central School District. I understand that by declining to enroll at this time I may subject myself and my eligible dependents to certain applicable waiting periods if I decide to enroll at a later date.

I do swear that I have other insurance providing health coverage. ***Attached is a copy of proof of this insurance.***

If your spouse is also employed by the District, please indicate name, title and location.

Spouses Name/Title/Location_____

NOTE: I understand that the Buy-Out payment is contingent upon receipt of this signed declination by the Benefits Department prior to the May 1st deadline. Failure to execute this declination by May 1st will result in a prorated reduction of the Buy-Out payment, If I wish to continue in the Buy-Out Program I will need to submit a new form along with proof of other insurance.

X _____ PRINT NAME

X _____ SOCIAL SECURITY # (last 4 digits)

X _____ SIGNATURE

X _____ DATE

RETURN THIS FORM TO CENTRAL OFFICE - BENEFITS DEPARTMENT no later than April 30th

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For Benefits Dept. Use Only

DOE: _____ Date First Eligible: _____ Date Paid _____ Amt: _____ Date Form Rec'd _____