

HEALTH INSURANCE BUY-BACK AGREEMENT

I, _____
Name of Employee (please print) School _____

I do fully understand the provisions of the Health Insurance Buy-Back Agreement stated in the existing contract covering my employee group. It basically states the following:

All employees whose spouse provides comparable health insurance coverage are not eligible for District-sponsored health insurance. Both insurance coverage and out-of-pocket costs will be considered in evaluating comparability. (Employees covered by a plan not deemed comparable might still voluntarily choose to participate in the buy-back plan). Employees who do not participate for a six-month period (July-December and/or January-June) shall receive payment of \$900 for each six-month period. To be eligible for this provision, employees must notify the District in writing on or before June 1 for the July-December period and on or before December 1 for the January-June period of their intention to waive health insurance coverage. Employees may still opt for the Buy-Back Agreement for the entire year, yet receive the separate payments.

Employees must also demonstrate that they have alternate health insurance coverage. Employees can reenter during any six-month period provided they can demonstrate the loss of comparable coverage. Such employees shall only be eligible for the prorated share of the lump sum benefit. Employees should check next to the appropriate number below:

1. I have comparable coverage under my spouse's plan. I am therefore ineligible to receive District-sponsored health insurance. I am therefore entitled to the District buy-out of \$1,000 for the six-month period of July 1st through December 31st and/or January 1st through June 30th.

1. a **Part-time Paraprofessionals** (six hours or less daily) who are not eligible for benefits will receive a lump sum of \$550 payable in June.

2. I am covered by another health insurance plan but it is not comparable to the District's plan. I am therefore requesting that I remain in the District's plan. Attached is the completed "Health Insurance Comparability Checklist" form. I understand the District will make a determination on comparability and will consult with the Association over this issue. I understand that if I subsequently become covered by another health insurance plan, I will advise the District of this event and a determination on comparability will be made at that time. (The Health Insurance Comparability Checklist can be obtained by contacting the Benefits Coordinator - 457-2400 extension 8125).

3. I am covered by another health insurance plan that is not comparable to the District's plan. I nevertheless choose not to participate in the District's current plan and accept the buy-out.

If you receive the buy back, you may either be paid on one or two installments. Please check one (if applicable).
 One installment Two installments

I opt to take this buy-back voluntarily.
I am obligated to take this buy-back based on the contract.

I understand that payment will be made in the last month of the six-month period, and I further understand that if there is any change in the present amount, I shall be entitled to that change.

Date	Employee's Signature	Position (Teach, Para, etc)
1. Name of individual who has alternate health insurance coverage _____		
2. Relationship of individual to you _____		
3. Name of employer providing alternate coverage _____		
4. Name of health insurance plan giving you alternate coverage _____		

Please complete entire form and return to the Payroll Department.