Herscher Community Unit School District No. 2
DR. RICHARD S. DECMAN, SUPERINTENDENT
JILL FULTON, SPECIAL SERVICES DIRECTOR
DR. PETE FALK, CURRICULUM DIRECTOR

Annual Health Insurance Waiver

Insurance Opt-Out for the following time frame:
7.1.2025 – 6.30.2026 (FY26)

I, *(Printed Name)* _____, have declined health coverage in the online benefits system AND choose to receive an opt-out stipend of *up to $450.00/year* ($18.75/pay period.)

☐ I understand that I am obligated to provide proof of other, current health insurance coverage for myself.

Employee Signature: _____ Date: _____

Acceptable forms of proof of other coverage *(check one)* :

☐ A copy of your current health insurance card that lists your name as a covered dependent/individual.

- OR -

☐ Letter from the employer of other coverage that lists your name as a covered dependent/individual on their plan.

To be eligible for the (up to) $450.00/year ($18.75/pay period) stipend, you must *(do both)*:

☐ Decline health insurance in the online benefit system

- AND -

☐ Turn in this signed waiver with proof of coverage to the Unit Office Attn: HR/PR Dept no later than 14 days after receiving your insurance information.

District Office Use Only

Received: _____ By: _____

Proof Attached: ☐ Type of Proof Submitted: _____