

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:  
**7.1.2026 – 6.30.2027 (FY27)**

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.)**

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.

Acceptable Forms of Proof of Other Coverage include:

- A copy of your current insurance card – Must list your name
- A letter from the employer of other coverage that lists your name as a covered individual
- I understand that I am obligated to provide proof of other current health insurance coverage for myself to receive the above-mentioned insurance opt-out stipend.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I, *(Printed Name)* \_\_\_\_\_, have **declined** health coverage in the online benefits system **AND** acknowledge that if I do not submit proof of other coverage, I will not receive the insurance opt out stipend.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

----- District Office Use Only -----

Received: \_\_\_\_\_ By: \_\_\_\_\_

Proof Attached: \_\_\_ Type of Proof Submitted: \_\_\_\_\_

*"Education... The Ultimate Investment."*