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)

Form has changed. Please read carefully.

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."

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