SUNY SCHENECTADY
COUNTY COMMUNITY COLLEGE

BONUS FOR WAIVER OF HEALTH INSURANCE BENEFITS
(CSEA) – 2022

Schenectady County offers employees who are enrolled in County subsidized health insurance coverage the option to decline such coverage, and receive cash payments in lieu of insurance coverage. The value of such cash payments is $4,000 for waiver of family coverage and $2,000 for waiver of individual coverage. Proof of alternate insurance coverage, both for the employee and for any eligible dependents (if applicable), must be presented in order to participate. Acceptable proof is a letter completed by an employer or insurance company verifying coverage including each covered family member. **THIS IS AN ANNUAL ELECTION. You must complete this form each year that you are eligible, during open enrollment.**

Last Name: _____ First Name: _____

Soc. Sec. No.:_____ Job Title: _____

Department: _____ Employment Date:_____

Please answer the following questions:

1. Are you currently enrolled in Schenectady County health insurance? ☐ Yes ☐ No

If no, termination/change date _____(will be effective last day of month received)

2. Indicate current health insurance coverage:
   ☐ Enrolled in individual coverage
   ☐ Enrolled in family coverage

3. Indicate health insurance waiver amount:
   ☐ Individual coverage ($2000)
   ☐ Family coverage ($4000)

4. Indicate your bargaining unit:
   ☐ CSEA ☐ Management
   ☐ L1199/721 ☐ SSBA

If you have <u>family</u> coverage, please answer the following additional questions:

Is your spouse an employee of Schenectady County or SCCC? ☐ Yes ☐ No
If no, attach proof of other coverage and sign and date completed form;

If yes, please indicate spouse's County department_____
Spouse's name _____

If both you and your spouse are county employees, you are eligible for 1 of 2 benefit options as outlined in your current union contract under <u>Dual Enrollment of Spouses.</u>

Please contact the Human Resources Office to obtain the necessary form to take advantage of this benefit.

Employee Certification

I certify that I am freely and voluntarily declining health insurance coverage that would ordinarily be offered to me in lieu of a cash payment offered through the health insurance buy-out option. I certify the above information is correct to the best of my knowledge. I have attached proof of alternate insurance coverage. Further I understand:

1. I will be expected to re-certify my eligibility to participate in this program every year.

2. I must report all changes in my eligibility status immediately to my department.

3. The County will seek recovery of any overpayment of health insurance buy-out benefits.

_____ _____

Employee Signature Date

_____ _____

Executive Director of Human Resources Date

_____ _____

College President Date

_____

Effective Date Assigned

If terminating or changing health insurance coverage to enter buy-out program, the termination/change forms, which are available for the Human Resources Office, **must** be attached to this election form (along with proof of alternate coverage and proof of eligibility, if required). Failure to provide all necessary documentation will delay the effective date of buy-out benefits.

Submit forms to: Office of Human Resources
Elston Hall, Room 511