INSURANCE INCENTIVE APPLICATION

PLEASE READ CAREFULLY AND SELECT THE OPTION THAT APPLIES TO YOU:

OPTION 1 – Incentive In Lieu of Total Insurance Package:

1) I am presently an employee of the River Valley Local School District.

A) I was enrolled and insured under the River Valley School District TOTAL Insurance Plan (Hospital, Major medical, Dental) as of June 30, 1989, or

B) I was hired after the June 30, 1989 date and now elect to apply for the insurance incentive in lieu of enrollment in the total Insurance Plan (Hospital, Major Medical, Dental).

I am refusing membership in the River Valley Total Insurance Plan (Hospital, Major Medical, Dental) for the enrollment period of January 1, 2019 – December 31, 2019, and elect to receive a one-thousand dollar ($1,000) cash Incentive, or if I am a 50% contract employee, elect to receive a five hundred dollar ($500) cash incentive.

I understand I must be covered under another group with Total Insurance (Hospital, Major Medical, Dental) coverage to exceed or equal my present coverage.

*Complete this section if you currently have **health** and **dental** insurance.*

MANDATORY INFORMATION:

The name of the medical plan I am enrolled under as of January 1, 2019:

____

Policy Holder Name _______________________________

Policy Holder Employer _____________________________

The name of the dental plan I am enrolled under as of January 1, 2019:

____

Employee Signature _________________**Date** __________

OPTION 2 – Incentive In Lieu of Medical Coverage Only

*Complete this section if you currently have **health** insurance (no dental insurance coverage).*

2) I am presently an employee of the River Valley Local School District.

A) I was enrolled and insured under the River Valley School District Medical Insurance Plan only (Hospital, Major Medical) as of June 30, 1989, or

B) I was hired after the June 30, 1989 date and now elect to apply for the insurance incentive in lieu of enrollment in the Medical Insurance Plan only (Hospital, Major Medical).

I am refusing membership in the River Valley Medical Insurance Plan ONLY (Hospital, Major Medical) for the enrollment period January 1, 2019– December 31, 2019 and elect to receive five-hundred dollars ($500) cash incentive, or if I am a 50% contract employee, I elect to receive a two-hundred and fifty dollar ($250) cash incentive.

I understand I must be covered under another group with a medical insurance (hospital, major medical) coverage to exceed or equal my present coverage.

MANDATORY INFORMATION:

The name of the medical plan I am enrolled under as of January 1, 2019:

____

Policy Holder Name _______________________________

Policy Holder Employer _____________________________

Employee Signature ______________________**Date** _________

River Valley Local School District

James P. Peterson
Superintendent

Cathyrn Zimmer
Treasurer

River Valley Administration
197 Brocklesby Rd.
Caledonia, Ohio 43314
TEL (740) 725-5400
FAX (740) 725-5499

River Valley High School
David J. Coleman, Principal
4280 Marion-Mt. Gilead Rd.
Caledonia, Ohio 43314
TEL (740) 725-5800
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River Valley Middle School
Donald W. Gliebe, Principal
4334 Marion-Mt. Gilead Rd.
Caledonia, Ohio 43314
TEL (740) 725-5700
FAX (740) 725-5799

Heritage Elementary School
Melanie S. Comstock, Principal
720 Columbus-Sandusky Rd. S.
Marion, Ohio 43302
TEL (740) 725-5500
FAX (740) 725-5599

Liberty Elementary School
Sandra K. Richards, Principal
1932 Whetstone River Rd. N.
Caledonia, Ohio 43314
TEL (740) 725-5600
FAX (740) 725-5699

DISTRICT WEB ADDRESS:
www.rvk12.org

RIVER VALLEY LOCAL SCHOOLS
WAIVER OF COVERAGE FORM
ACCOUNT NUMBER 76411227

The River Valley Local Schools Employee Benefit Plan contains provisions to allow employees who decline coverage for themselves and/or their dependents because they have coverage under another group health plan or other health insurance, to enroll in the Plan as a special enrollee if they lose the other coverage. However, in order to be a special enrollee, the Plan requires that you state in writing that coverage under group health plan or other health insurance coverage was the reason for declining enrollment in the Plan. If you do not provide the written statement you will not be able to qualify as a special enrollee in the event that you lose your other coverage and you will not be able to enroll in the plan if you lose your other coverage.

I have been offered coverage under the Plan. I hereby decline to participate in the Plan for the following coverage:

_______ Employee Medical Benefits
_______ Dependent Medical Benefits
_______ Employee Drug Benefits
_______ Dependent Drug Benefits

Check one:

______ 1. The reason that I have declined coverage for the above benefits is because the people who would receive the benefits that have been declined, have coverage under another group health plan or other health insurance.

______ 2. The reason that I have declined coverage for the above benefits is for reasons other than those stated in #1 above. I understand and agree that by checking this option, I will not be able to qualify as a special enrollee due to the loss of coverage under another group health plan or other health insurance.

Employee Name: ________________________________ Date:__________

Employee Signature: _____________________________

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RIVER VALLEY LOCAL SCHOOLS
WAIVER OF COVERAGE FORM
Vision

The River Valley Local School Board offers Vision benefits to employees. Enrollment in this plan in voluntary. The District administers this plan in the same manner as medical. Medical has a provision to allow employees who decline coverage for themselves and/or their dependents because they have coverage under another group plan or other insurance, to enroll in the Plan as a special enrollee if they lose the other coverage. However, in order to be a special enrollee, the Plan requires that you state in writing that coverage under group plan or other insurance coverage was the reason for declining enrollment in the Plan. If you do not provide the written statement you will not be able to qualify as a special enrollee in the event that you lose your other coverage and you will not be able to enroll in the plan if you lose your other coverage.

I have been offered coverage under the Plan. I hereby decline to participate in the Plan for the following coverage:

_______ Employee Vision Benefits
_______ Dependent Vision Benefits

Check one:

______ 1. The reason that I have declined coverage for the above benefits is because the people who would receive the benefits that have been declined, have coverage under another group plan or other insurance plan.

Vision Provider: ________________________________
Vision Policy Holder: _____________________________

______ 2. The reason that I have declined coverage for the above benefits is for reasons other than those stated in #1 above. I understand and agree that by checking this option, I will not be able to qualify as a special enrollee due to the loss of coverage under another group health plan or other health insurance.

Employee Name: ______________________________ Date ___________

Employee Signature: ____________________________