

**WAPPINGERS CENTRAL SCHOOL DISTRICT  
2016-17 HEALTH INSURANCE SHARED SAVINGS PLAN REGISTRATION FORM**

Employees eligible for District-provided health insurance who are enrolled for alternate health insurance coverage have the option of receiving an annual shared savings or “buyout” payment in lieu of coverage. To be eligible for a buyout payment, an employee must submit this form, with proof of alternate coverage attached, to the Office of Human Resources. An employee who has not yet withdrawn from District coverage must also submit a completed DEHIC form with “Cancel Coverage” checked in Section 2 of the form. **You must timely file this registration form and the required attachment(s) in order to receive a buyout payment.** Do not file this form if you are currently receiving a buyout payment from the District.

For an employee who becomes eligible to enroll or re-enroll for District-provided coverage, this form, with proof of alternate coverage attached, must be received in the HR Office no later than 60 calendar days of the date of the employee’s health insurance eligibility date. For employees enrolled for District coverage who have dropped or intend to drop District coverage, this form must be filed no later than June 30.

An employee who does not enroll for coverage within 60 calendar days of eligibility or who drops coverage will remain without District-provided coverage until he/she submits a new health insurance enrollment application and an effective date of coverage is confirmed by the District. An employee may submit an enrollment application only during the May open enrollment period, with coverage effective July 1, unless a qualifying event occurs that provides the employee with a special open enrollment window. Contact the District’s health insurance representative for additional information regarding qualifying events.

Each school year after buyout registration, half the annual buyout payment will be paid to the employee in February and half in June. In the first year of buyout registration, employees who become eligible to enroll or re-enroll for coverage effective July 1 through November 1 will receive both payments provided this registration form with the required attachments is submitted timely. Those who become eligible for coverage effective November 2 through April 1 will receive only the June payment. Those who become eligible April 2 through June 30 will not receive payment until the following school year. An employee who drops District coverage effective any date after July 1 and who files this form with the required documents attached will not receive a buyout payment until the following school year. An employee who is registered for the buyout and who enrolls for coverage effective prior to July 1 due to a qualifying event must repay to the District any buyout payments made during the current school year. Buyout payments will be prorated for periods an employee is not eligible for District coverage due to no-pay or leave status of more than 30 consecutive days.

----- **DO NOT DETACH** -----

I wish to register for the health insurance shared savings plan under the terms described above and have attached proof of alternate coverage and, where applicable, a DEHIC “cancel coverage” form. I understand that a copy of this registration form will be returned to me by the HR Office within 30 calendar days of receipt as proof that my buyout registration has been approved. I further understand I must retain a copy of the approved form for my records and, if I do not receive an approved copy within 30 calendar days of submission, I must contact the HR Office in order to assure payment.

|           |            |      |                  |
|-----------|------------|------|------------------|
| Signature | Print Name | Date | School/ Location |
|-----------|------------|------|------------------|

----- **DO NOT DETACH** -----  
**FOR HR OFFICE USE ONLY**

|   |  |
|---|--|
| _____ Eligibility confirmed                     | _____ Proof of alternate coverage received |
| _____ Completed DEHIC form received if required | _____ Anticipated 2016-17 annual payment   |

|  |      |
|--|------|
| Approved by WCSD Office of Human Resources | Date |
|--|------|