Herscher Community Unit School District No. 2
DR. RICHARD S. DECMAN, SUPERINTENDENT
SHELLY PARSONS, SPECIAL SERVICES DIRECTOR
DR. PETE FALK, CURRICULUM DIRECTOR

Health Insurance Waiver

Insurance Opt-Out for the following time frame:
7.1.2024 – 6.30.2025 (FY25)

I, *(Printed Name)* _____, have declined health insurance coverage in the online benefit system (Benefit Solver) and choose to receive an opt-out insurance stipend of *up to* $450.00/year ($18.75/ pay period).

I understand that I am obligated to provide proof of other, current health insurance coverage for myself.

Acceptable forms of proof of coverage:

1. A copy of your current health insurance ID card that clearly indicates indicates you are a covered individual, *OR*
2. Letter from employer of other coverage that clearly names you as a dependent on the plan.

To be eligible for the (*up to*) $450.00 / year ($18.75/pay period) stipend, you **must**:

1. Decline health insurance in our online benefit system (Benefit Solver) *AND*
2. Turn in this signed letter with proof of coverage (as listed above) to Heather Crane, HR/PR Clerk in the Unit Office no later than 14 days after receiving your insurance information.

Employee Signature: _____ Date: _____

District Office Use Only

Received: _____ By: _____

Proof Attached: ☐ Type of Proof Submitted: _____

"Education... The Ultimate Investment."

District Office: 501 North Main Street, PO Box 504, Herscher Illinois 60941-0504
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