

**Lumberton Board of Education**

**Aetna Medical Benefits Waiver – Non Represented Members**

Employee Name: \_\_\_\_\_

School Year: 2021 - 2022

**I would like to waive the following Aetna Medical Coverage (SELECT ONE):**

- |                                      |                          |
|--------------------------------------|--------------------------|
| Aetna Choice POS II \$10 Copay       | <input type="checkbox"/> |
| Aetna Choice POS II \$15 Copay       | <input type="checkbox"/> |
| Aetna Choice POS II \$15/\$25 Copay  | <input type="checkbox"/> |
| Choice POS II \$20/\$30 Copay        | <input type="checkbox"/> |
| Choice POS II \$20/\$35 Copay        | <input type="checkbox"/> |
|                                      |                          |
| QPOS \$10 Copay                      | <input type="checkbox"/> |
| QPOS \$20 Copay                      | <input type="checkbox"/> |
| QPOS \$20/\$35 Copay                 | <input type="checkbox"/> |
| ** New Jersey Educator's Health Plan | <input type="checkbox"/> |

\*\* All employees hired after 7/1/2020 who are waiving coverage must choose to waive the New Jersey Educator's Health Plan

**YOU MUST SUBMIT A COPY OF YOUR CURRENT INSURANCE CARD WITH THIS FORM.**

I am waiving the following coverage:

- |                 |                          |                 |                          |
|-----------------|--------------------------|-----------------|--------------------------|
| Employee Only   | <input type="checkbox"/> | Employee/Spouse | <input type="checkbox"/> |
| Parent /1 Child | <input type="checkbox"/> | Parent/Children | <input type="checkbox"/> |
|                 |                          | Family          | <input type="checkbox"/> |

Employee Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Date Received in Board Office: \_\_\_\_\_

Payroll and Benefits Signature: \_\_\_\_\_

**PLEASE RETURN COMPLETED FORM to Payroll and Benefits by May 14, 2021.**