SCHOOL DISTRICT OF
FORT • ATKINSON

BUSINESS SERVICES
201 PARK STREET
FORT ATKINSON, WI 53538
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TO: **Employees Represented by FEA, Inc.**

FROM: **Jason P. Demerath, Director of Business Services**

DATE: **May 14, 2010**

RE: **Waiving Health and/or Dental Coverage and Receiving Cash Benefits**

This memorandum is directed to all employees who are represented by FEA, Inc. that wish to receive cash compensation in lieu of the group health and/or dental insurance coverage offered by the School District of Fort Atkinson.

Under the 2009-11 collective bargaining agreement, the School District of Fort Atkinson has agreed to provide an estimated $183.90 per month to each employee working half-time or more represented by FEA, Inc. that waives the School District of Fort Atkinson's group health insurance coverage, and an estimated $14.31 per month for waiving the group dental insurance. [The $183.90 and $14.85 amounts are based on a 10% and 6% increase in the 2009/10 single insurance premiums for health and dental insurance, respectively.] In order to receive this compensation in lieu of these benefits, ***federal regulations require you to prove*** you are covered under another health and/or dental insurance plan.

Beginning with the September 2010 payroll, for those eligible employees waiving the School District of Fort Atkinson's group health and/or dental insurance coverage, the School District will add an estimated $183.90 per month to your income for waiving health insurance, and an estimated $14.31 per month for waiving dental insurance, as gross compensation. The monies will be treated as regular taxable wages. Please note that the health insurance amount will be prorated if you are employed less than full-time (1.0 FTE) in the same manner as the premium cost for the insurance would have been.

If you are interested in cash compensation in lieu of the School District's group health and/or dental insurance coverage you must complete the attached form(s). Be sure to attach to the form(s) proof that you are covered under another health and/or dental insurance plan. An example of "proof" is a coverage confirmation form from the insurance company, NOT a photocopy of an insurance ID card. If your spouse is an employee of the District and is the primary carrier of the District's coverage, it is still necessary to provide a confirmation from Dean Health Plan that you are covered under your spouse's insurance. ***For new employees only***, due to time constraints, we will accept a photocopy (front and back) of your spouse's insurance ID card with a signed statement on the photocopy stating the following, "I certify that this insurance will provide qualified health (or dental, whichever is appropriate) coverage for me." Return the form(s) and proof(s) of coverage to my attention via interoffice mail to Luther Administration, or to the following address:

Jason P. Demerath
Director of Business Services
School District of Fort Atkinson
201 Park Street
Fort Atkinson, WI 53538

The ***deadline for applying*** for cash compensation in lieu of the School District of Fort Atkinson's group health and/or dental insurance coverage is ***4:00p.m. on August 31, 2010***. If your application is not received in the Business Office by this time you will not be eligible for the benefit until the 2011/12 school year per section 3.12(6)(B) of the 2009-11 collective bargaining agreement. *Please note that an application in transit at the time listed above is not considered received.*

Should you have any questions concerning this matter, please contact me at the address or phone number listed above.

SCHOOL DISTRICT OF FORT • ATKINSON

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BUSINESS OFFICE

CASH IN LIEU OF HEALTH INSURANCE COVERAGE APPLICATION FORM

This form is used to apply for the cash in lieu of the health insurance benefit for those employees represented by FEA, Inc. as outlined in the 2009-11 collective bargaining agreement. Please call Jason P. Demerath, Director of Business Services at 920.563.7800 if you have any questions.

I agree to waive the group health insurance coverage offered by the School District of Fort Atkinson in order to receive cash compensation in lieu of the Employer's group health insurance coverage.

The effective date for my waiver of the group health insurance coverage the Employer provides will be 12:01 a.m. on September 1, 2010 for new employees and 12:00 midnight on September 30, 2010 for employees who currently participate in the District's health insurance plan. I agree that I (and any family members or legal dependents) will not be eligible for reimbursement of my (our) health expenses from the Employer's group health insurance coverage provider that were incurred after the above effective date of my waiver for the Employer's group health insurance coverage. I agree that I (and any family members or legal dependents) will not be eligible for reimbursement of my (our) health expenses from the Employer.

Furthermore, I agree to verify once per plan year that I (and any family members or legal dependents) have health insurance coverage from another source for that plan year. Qualified health insurance coverage is defined by the Employer.

I agree that my election to waive the Employer's group health insurance coverage cannot be changed mid-plan year unless I have a qualified status change. **I further agree that, unless there is an open enrollment period or a qualifying event, I (we) may not be able to join the Employer's group health insurance coverage in the future. If allowed to enroll in the Employer's group health insurance plan (for a reason other than open enrollment or a qualifying event), I (we) may have group health insurance coverage restrictions and/or may have to prove insurability.**

In lieu of the Employer's group health insurance coverage, I elect to receive cash compensation in the estimated amount of $183.90 per month from the Employer. [The estimated $183.90 is based on a 10% increase of the single insurance premium rate for 2009/10 and will be prorated if you are employed less than full-time.] I agree that the cash compensation is taxable income.

Please check one of the following:

In 2009-2010…

_____ I had individual health insurance in my name
_____ I had family health insurance in my name
_____ I had no health insurance in my name
_____ I was not employed by the School District of Fort Atkinson (I am a new employee)

EMPLOYEE'S NAME:_____ (please print)

EMPLOYEE'S SIGNATURE:_____ **DATE**: _____

ADDRESS:_____

WITNESS' NAME:_____ (please print)

WITNESS' SIGNATURE:_____ **DATE**: _____

BE SURE TO ATTACH PROOF OF QUALIFIED HEALTH INSURANCE FROM ANOTHER SOURCE

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BUSINESS OFFICE

CASH IN LIEU OF DENTAL INSURANCE COVERAGE APPLICATION FORM

This form is used to apply for the cash in lieu of the dental insurance benefit for those employees represented by FEA, Inc. as outlined in the 2009-11 collective bargaining agreement. Please call Jason P. Demerath, Director of Business Services at 920.563.7800 if you have any questions.

I agree to waive the group dental insurance coverage offered by the School District of Fort Atkinson in order to receive cash compensation in lieu of the Employer's group dental insurance coverage.

The effective date for my waiver of the group dental insurance coverage the Employer provides will be 12:01 a.m. on September 1, 2010 for new employees and 12:00 midnight on September 30, 2010 for employees who currently participate in the District's dental insurance plan. I agree that I (and any family members or legal dependents) will not be eligible for reimbursement of my (our) dental expenses from the Employer's group dental insurance coverage provider that were incurred after the above effective date of my waiver for the Employer's group dental insurance coverage. I agree that I (and any family members or legal dependents) will not be eligible for reimbursement of my (our) dental expenses from the Employer.

Furthermore, I agree to verify once per plan year that I (and any family members or legal dependents) have dental insurance coverage from another source for that plan year. Qualified dental insurance coverage is defined by the Employer.

I agree that my election to waive the Employer's group dental insurance coverage cannot be changed mid-plan year unless I have a qualified status change. **I further agree that, unless there is an open enrollment period or a qualifying event, I (we) may not be able to join the Employer's group dental insurance coverage in the future. If allowed to enroll in the Employer's group dental insurance plan (for a reason other than open enrollment or a qualifying event), I (we) may have group dental insurance coverage restrictions and/or may have to prove insurability.**

In lieu of the Employer's group dental insurance coverage, I elect to receive cash compensation in the estimated amount of $14.31 per month from the Employer. [The estimated $14.31 is based on a 6% increase of the single insurance premium rate for 2009/10.] I agree that the cash compensation is taxable income.

Please check one of the following:

In 2009-2010…

_____ I had individual dental insurance in my name
_____ I had family dental insurance in my name
_____ I had no dental insurance in my name
_____ I was not employed by the School District of Fort Atkinson (I am a new employee)

EMPLOYEE'S NAME:_____ (please print)

EMPLOYEE'S SIGNATURE:_____ **DATE**: _____

ADDRESS:_____

WITNESS' NAME:_____ (please print)

WITNESS' SIGNATURE:_____ **DATE**: _____

BE SURE TO ATTACH PROOF OF QUALIFIED DENTAL INSURANCE FROM ANOTHER SOURCE