SCHOOL DISTRICT OF
FORT • ATKINSON

BUSINESS SERVICES
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TO: **Staff With Individual Contracts Under § 118.22 Wis. Stats. And Professional/Exempt Non-Supervisory Employees (Those Formerly Covered Under the FEA Agreement)**

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

DATE: **May 22, 2014**

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

This memorandum is directed to all employees covered under Part II of the *Employee Handbook* 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.

As outlined in the *Employee Handbook*, the School District of Fort Atkinson has agreed to provide $87.54 per pay period to each employee working half-time or more covered under Part II of the *Employee Handbook* that waives the School District of Fort Atkinson's group health insurance coverage, and $6.64 per pay period for waiving the group dental insurance. 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 15, 2014 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 $87.54 per pay period to your income for waiving health insurance, and $6.64 per pay period 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 letter from the insurance company. 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 that you are covered under your spouse's insurance. We will accept a photocopy (front and back) of your spouse's insurance ID card ***that shows your name as covered*** 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 29, 2014***. If your application is not received in the Business Office by this time you will not be eligible for the benefit until the 2015/16 school year per Part II, Section 8.08 of the *Employee Handbook*. *Please note that an application in transit at the time listed above is not considered received.* Please see the next page for the excerpt from the *Employee Handbook* concerning this benefit. Should you have any questions concerning this matter, please contact me at the address or phone number listed above.

8.08 Cash in Lieu of Insurance (hereinafter "CLI")

A. Availability

Teachers working half-time or more may elect a cash payment in lieu of ("CLI") the District's health and/or dental insurance benefits. This CLI option shall be available to all teachers consistent with any open enrollment periods established by the District.

Note: Absent a "qualifying event" (such as employee marriage, loss of spouse coverage, etc.), employees who forego enrollment in either the health and/or dental insurance coverage (at either the point of initial eligibility as a new District employee or at any point during employment with the District), should expect to have to prove insurability (i.e., go through health/dental underwriting), accept restrictions on coverage for pre-existing conditions, or wait for the next "open enrollment period" in order to enroll at a later date.

Teachers shall have the ability to enroll in the health and/or dental insurance plans when a qualifying event occurs. Upon entry into the District's health and/or dental insurance plans, however, that employee's participation in the CLI program shall cease.

B. Employee Election

Prior to September 1 of each year current employees wishing to elect the CLI benefit for the upcoming school year shall complete a District-provided application. This application will require proof that the employee is covered under another health and/or dental insurance plan. Absent a mid-year (September through August) exception (such as an employee changing to her/his spouse's coverage, etc.), employees must make a written annual CLI election prior to each September 1. When a mid-year exception occurs and an election is made, payment of the CLI benefit shall begin the month following the District's receipt of the election and required proof of other coverage.

1. Employee Election for New Employees

Payments shall be based on the employee's eligibility date, which is the first of the month following the first day worked. Employees not electing health and/or dental coverage, and those who are not permitted to elect health and/or dental coverage because they are married to staff members of the District who have elected health and/or dental coverage, where eligible, may elect the CLI option no later than September 1 or their first day of work if after September 1. Employees who fail to elect the CLI option before September 1 or their first day of work must wait until the next school year.

C. CLI Benefit Amount & Payment

The monthly payment amount of the CLI benefit will be equal to forty percent (40%) of the District's cost for an individual (not family) health or dental plan less any applicable payroll expenses (e.g., social security, etc.). For part-time employees, the cash payment will be prorated in the same manner as the District's contribution to the cost of the insurance for individual (not family) coverage would have been.

D. Effective Date/Trial Period

This provision shall become effective for the 2010-2011 school year. This provision shall cease to exist and will be removed from the *Handbook* as of August 31, 2015 unless the Board determines to continue this benefit thereafter. Should this provision be removed as stated herein, a health and dental insurance open enrollment period shall be made available.

SCHOOL DISTRICT OF FORT • ATKINSON

2014 – 2015

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 covered under Part II of the *Employee Handbook*. 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, 2014 for new employees and 12:00 midnight on September 30, 2014 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 amount of $87.54 per pay period from the Employer. I agree that the cash compensation is taxable income.

Please check one of the following:

In 2013-2014…

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

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

SCHOOL DISTRICT OF FORT • ATKINSON

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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 covered under Part II of the *Employee Handbook*. 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, 2014 for new employees and 12:00 midnight on September 30, 2014 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 amount of $6.64 per pay period from the Employer. I agree that the cash compensation is taxable income.

Please check one of the following:

In 2013-2014…

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

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