

PASSAIC PUBLIC SCHOOLS

*Office of Human Resources
101 Passaic Avenue, P.O. Box 388
Passaic, New Jersey 07055-0388*

**PRESCRIPTION DRUG COVERAGE
OPT-OUT AND OPT-IN
COVERAGE WAIVER/REINSTATEMENT**

Part 1: To be completed b the employee. Please print (using blue ball point pen).

1. Name _____ **SS #** _____

Check one box below:

Waiver of Coverage

In accordance with collective bargaining agreement, I have agreed to waive prescription drug coverage offered by the Passaic Board of Education.

In place of prescription drug coverage, the Passaic Public Schools will pay me the amount shown in Part 2 below. I understand that I may resume prescription drug coverage when I have a change of life circumstance (marital status, addition or loss of dependent, change in work status of spouse), provided that I notify the Passaic Board of Education, Office of Human Resources **within 60 days of the loss of the other coverage and provide proof of loss of that coverage.**

Reinstatement of Coverage

I previously waived prescription drug coverage offered by the Passaic Public Schools because I had other prescription drug coverage.

As of _____, I am no longer covered by the other prescription drug coverage, and request reinstatement of prescription drug coverage provided by the Passaic Public Schools, and I have provided proof of the loss of the other coverage.

Employee's Signature _____ **Date** _____

Part 2: To be completed by the employer. Check one box below.

We will pay the above employee \$_____ every **month** in place of providing prescription drug coverage. We understand that this payment may not be more than 25% of the amount saved by the employer because of the voluntary waiver.

We request reinstatement of this employee's prescription drug coverage provided by the Passaic Board of Education.

A completed *prescription drug* application must be attached to either a waiver or reinstatement.

If the application for waiver is received by the Passaic Board of Education by the 5th of the month, the change will take place on the first of the following month. The reinstatement application must be filed within 60 days of the loss of other prescription drug coverage. If this timetable is followed, the coverage will be retroactive to the date of loss. Of the 60 day time limit has passed, the employee must wait until the next open enrollment period to reenroll.

Employer Name _____

Signature of School Business Administrator _____

Date _____