DEPARTMENT OF HUMAN RESOURCES
CHIEF ADMINISTRATIVE OFFICE
CITY OF NEW HAVEN

200 Orange Street, New Haven, CT 06510
(203) 946-8252
(203) 946-7166 fax
www.newhavenct.gov

JUSTIN ELICKER
MAYOR

REGINA RUSH-KITTLE
CHIEF ADMINISTRATIVE OFFICER

NEW HAVEN PUBLIC SCHOOLS

Medical Benefits Waiver – School Year 23-24

For Eligible Local 933 – Teachers

(OPT-OUT Part A)

In accordance with Article XIII, Section 1h, of the current Teachers Local 933 Contract*, I (full name)_____ have chosen to waive (opt out of) the medical benefit plan offered to me from September 1, 2023 through August 31, 2024.

I will receive a cash payment in lieu of medical benefit coverage at the end of the school year, as long as I am eligible, and I do not elect a medical plan offered by the City of New Haven during the period noted above.
(Payment for School Year 23-24 to be made in May / June 2024.)

I certify that all statements made in conjunction with this waiver are true, complete and correct to the best of my knowledge and belief and are made in good faith. I understand that incomplete, false or inaccurate information, regardless of when it is discovered, may result in forfeiture of payment under the Medical Benefits Waiver / Opt-Out Policy and may result in disciplinary action.

Signature_____ Date:_____

For June 2024 payment,
RETURN THIS FORM TO:
SBaldwin@newhavenct.gov
Return by June 30, 2023

For HR / Med Benefit Use ONLY:

Emp# _____

D-O ☐ CODE _____ ☐

S ☐ C ☐ F ☐

*Participation is restricted to employees who have continuously participated in the Opt Out Program since 13-14.

Form not valid without both pages (Part A & Part B) completed – PLEASE COMPLETE BOTH SIDES OF PAGE

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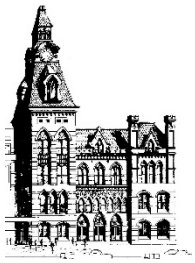

NEW HAVEN PUBLIC SCHOOLS

Medical Benefits Waiver – School Year 23-24

For Eligible Local 933 – Teachers

(OPT-OUT Part B)

Employee Name: _____ Employee #:_____

Current Address: _____

IMPORTANT: List persons who, if you *had* elected medical insurance coverage, would be included on your plan. The number of dependents affects the amount of your Opt-Out Payment for year 2023-2024.

	NAME	Last 4 #s of Social Security #	Date of Birth
Self		xxx-xx-	
Spouse		xxx-xx-	
Dependent Child		xxx-xx-	
Dependent Child		xxx-xx-	
Dependent Child		xxx-xx-	
Dependent Child		xxx-xx-	
Dependent Child		xxx-xx-	
Dependent Child		xxx-xx-	
Dependent Child		xxx-xx-	

(list any additional dependents on additional pages if needed)

CHECK **ONE** BELOW:

☐ **I CURRENTLY HAVE** Anthem Dental and I am electing to **continue** Dental coverage for myself and dependents as listed on the attached Enrollment & Membership Change Form.

☐ **I CURRENTLY HAVE** Anthem Dental and I am electing to **cancel** Dental coverage for myself and dependents as listed on the attached Enrollment & Membership Change Form.

☐ **I NOW WISH TO ENROLL OR ADD DEPENDENTS TO** my Anthem Dental plan as listed on the attached Enrollment & Membership Change Form. I have also attached required documentation as needed for verification purposes.

☐ **I DO NOT HAVE NOR DO I WISH TO ELECT** Anthem Dental coverage through the City of New Haven.

Signature_____ Date:_____

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