Department use only:

Approved:_____Effective date:_____

Cash-In-Lieu of Medical Coverage 2025

Employee Name _____Employee ID # _____

Street Address_____City_____State_____Zip_____

Phone number_____Work Location_____

Please read and initial ACH A D of the follo ing statements

certify that am co ered y another ualifying group medical insurance indi idual plans, medical cost sharing plans, and plans purchased on the marketplace **do not** qualify) and have attached verification of my coverage. **An ID card alone is not sufficient proof of coverage and cannot be accepted.**

_____ I elect to waive enrollment in Killeen ISD's Group Health Insurance. By doing so, I will receive additional taxable compensation.

_____ I understand that, by exercising the election to receive monthly payments, I will receive no benefits or coverage from any Killeen ISD Health Plan. If I wish to enroll in a Killeen ISD Health Plan, I must do so during the Annual Enrollment period or within 30 days of a qualifying event.

_____ I understand that I must decline medical and elect cash in lieu in the online enrollment for this form to be processed.

_____ To participate in the cash in lieu program for the Benefit year 2025, during the Annual Enrollment period of July 15-August 10, all employees covered by an outside group medical plan **must** submit all documentation no later than_____. Only those received prior to _____, will be eligible for a September payment. There will be no retroactive payment and no exceptions to the above deadlines. **Without proof of coverage, this form cannot be processed.**

_____ I understand this verification must be provided and must state that I and my taxable dependents will be covered under another health insurance plan effective September 1, 2024.

_____ All new employees must submit their forms within 30 days of their start date to be eligible to participate in the program for 2025. No late submissions will be accepted.

_____ In order for me to continue to qualify for this option, I must annually, or at each enrollment, re-enroll by submitting a form with updated proof of other Health Plan coverage during the Annual Enrollment period.

_____ I understand that I must notify the Benefits Department of any changes to my Health Plan within 30 days of the change.

_____ I understand that cash in lieu documents must be sent as scanned PDF attachments to the correct inbox or this form cannot be processed.

I therefore and hereby agree to all terms and conditions as contained in this Cash-in-Lieu Medical Form and acknowledge that the terms and conditions are fully understood. I understand that submitting a health coverage document that has been altered or falsified will result in ineligibility for cash in lieu participation for the 2024 plan year. I further certify that the information furnished is true and correct and understand that falsification of this form may result in action including repayment of cash-in-lieu payments.

Signature of Employee: _____ Date: _____