Department use only:

Approved:_____ Effective date:_____

Cash-In-Lieu of Medical Coverage

Employee Name_____ Employee ID #_____

Street Address_____ City_____ State_____ Zip_____

Phone number_____ Work Location_____

Please read each of the following statements and initial each box:

☐ I certify that I am covered by another qualifying group medical insurance (individual plans, medical cost sharing plans, and plans purchased on the marketplace **do not** qualify) and have attached verification of my coverage. **An ID card is not sufficient proof of coverage and cannot be accepted.**

Name of Medical Plan (See attached proof of coverage): _____

☐ 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 Open Enrollment period or within 30 days of a qualifying event.

☐ I understand this verification must be provided and must state that I will be covered under another health insurance plan effective January 1, 2023. **Without proof of coverage, this form cannot be processed.**

☐ During the annual Open Enrollment period (October 1-25) to participate in cash in lieu program for Benefit year 2023 all forms must be received by February 2, 2023. Only those received prior to January 15, 2023, will be eligible for a January payment. There will be no retroactive payment.

☐ All new employees must submit their forms within 30 days of their start date to be eligible to participate in the program for 2023. No late submissions will be accepted.

☐ In order for me to continue to qualify for this option, I must annually re-enroll by submitting a form with updated proof of other Health Plan coverage during the Open 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 therefore and hereby agree to all terms and conditions as contained in this Cash-in-Lieu Medical Form and that the terms and conditions are fully understood. 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:_____