NAME:_____

DISCONTINUANCE OR REDUCTION OF BASIC MEDICAL COVERAGE

PLEASE ATTACH A COPY OF YOUR CURRENT MEDICAL INSURANCE CARD WITH YOUR FORM SUBMISSION

I understand the following conditions will apply in connection with my intent to discontinue basic medical coverage:

1. In consideration of the cost savings to the District, I will receive a waiver bonus in the amount of_____.
   (2025-2026 School Year Waiver Bonus - $1,250.00 for more than 5 or more Years of Service, and $1,000 for under 5 Years of Service)

2. The Board, at its discretion, may offer this benefit in each benefit year. If offered, SSD employees will be notified of the bonus amounts and will have until the end of the open enrollment period (Friday, May 2, 2025) to decide.

3. In the event the medical benefits available to me outside the District are terminated or decreased (in accordance with IRS regulations), I will be permitted to rejoin the District's medical plan upon written notice to the District's Human Resource Specialist. In such an event, I will refund to the District any prorated portion of the bonus waiver, which was paid/reimbursed to me through a Section 125 plan.

4. **I would like the bonus paid to me in the following manner (select one below):**
   NOTE: If no selection is made, you will automatically be given Option B.
   - ☐ A*. Section 125 Flexible Spending Account with $_____deposited in my plan account for this school year. If there is any balance of waiver money not applied to the Section 125 Spending Account, the balance will be paid to the employee in two (2) equal installments as listed below. Note: If you have an HSA account this option is not available to you.
   - ☐ B. The payment amount in #1 above will be made in two (2) equal installments in the December 15th and May 15th pay of each school year.

5. **Medical Coverage (copy of your valid insurance card must be included w/this form):**
   Name of Medical Insurance Company: _____
   Employer Sponsoring the Plan: _____
   Name of Individual under Whom You are Covered: _____

6. **Type of coverage to be selected from the above medical insurance company:**
   ☐ Single ☐ Employee & Spouse ☐ Family ☐ Employee & Child ☐ Employee & Children

7. **The last month of my medical coverage before the discontinuance/reduction shall be** _____
   (Only if you had previous coverage with Springfield School District)

8. **Position with the District**:
   ☐ Administrator ☐ Teacher ☐ Support Staff ☐ Custodial/Maintenance

Employee and Plan Holder Signature:

_____ _____

Employee Signature Date Plan Holder Signature Date

If you are depositing all or part of your waiver into the Section 125 Flexible Spending Account, please notify Human Resources.