TULLY CENTRAL SCHOOL DISTRICT
WAIVER OF HEALTH INSURANCE

I, _____, attest to the fact that:

1. **I am a full-time, active employee of the Tully Central School District;**
2. **I am eligible for health insurance coverage at the Tully Central School District;**
3. **I am voluntarily waiving my health insurance for the _____ -- _____ school year in return for payment of $1,000.00; to be made in quarterly installments on October, January, April, and June in your regular payroll check.**
4. **I understand that I will be unable to obtain health insurance for the school year indicated above after September 30 of that year, unless there are extenuating circumstances requiring me to obtain insurance.**

I fully understand that I have the option, upon thirty days written notice to the school district, of obtaining health insurance coverage according to the regulations set forth by Excellus Blue Cross Blue Shield of CNY. Monies paid to me for the stipend above will be adjusted pro rata and I will be responsible for reimbursing the school district for any excess monies that I have received based on the pro rata adjustment.

Signed: _____ Print this Form

Date: _____

Please return one signed copy to Donna Doody in the Business Office for verification and payment. Thank you.