

**TULLY CENTRAL SCHOOL DISTRICT**  
**WAIVER OF HEALTH INSURANCE**  
**2024-2025**

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 Tully Central School District
3. I am voluntarily waiving my health insurance for the 2024-2025 school year in return for payment of \$1,000 to be paid in quarterly installments of \$250.00 on October 11, 2024, January 03, 2025, April 11, 2025, and June 06, 2025. Payment will be in your regular paycheck. Unless request made for a separate check.
4. I understand that I will be unable to obtain health insurance for the 2024-2025 school year after September 30<sup>th</sup> unless there is an extenuating circumstance requiring me to obtain insurance.

I fully understand that I have the option, upon thirty (30) 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 I have received based on the pro rata adjustment.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please return one (1) signed copy of this form to Carol Beck in the Business Office for verification and payment. Thank you.