

**PRESCRIPTION COVERAGE WAIVER/REINSTATEMENT  
TOWNSHIP OF OCEAN BOARD OF EDUCATION  
to be submitted with the**

**COVERAGE WAIVER/REINSTATEMENT FOR LOCAL GOVERNMENT/EDUCATIONAL EMPLOYEES  
STATE HEALTH BENEFITS PROGRAM SCHOOL EMPLOYEES' HEALTH BENEFITS PROGRAM**

**Part 1:** To be completed by the employee. Please print.

1. Name \_\_\_\_\_ SS# \_\_\_\_\_

**Waiver of Coverage**

I have agreed to waive prescription coverage with the Township of Ocean Board of Education to which I am entitled. I understand that I am not eligible for the waiver incentive unless I waive both the SEHBP health and the OTBE prescription coverages.

In place of health and prescription coverage, my employer will pay me the amount shown on the attached **COVERAGE WAIVER/REINSTATEMENT FOR LOCAL GOVERNMENT/EDUCATIONAL EMPLOYEES STATE HEALTH BENEFITS PROGRAM SCHOOL EMPLOYEES' HEALTH BENEFITS PROGRAM** form. I understand that I may resume SEHBP health and/or OTBE prescription coverages when I am no longer covered by the other health coverage, provided that I notify the Health benefits Bureau and OTBE within 60 days of the loss of the other coverage and provide proof of loss of that coverage.

Signature \_\_\_\_\_

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

Please return this form to the Benefits Coordinator, Township of Ocean BOE, 163 Monmouth Rd., Oakhurst, NJ 07755, (732) 531-5600, ext. 3102.

***Note: The waiver of medical/prescription coverage does not affect enrollment for dental coverage. If you wish to waive dental coverage, a separate Dental Waiver form must be completed.***