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 Patricia DeAngelis, 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.