

Colts Neck Township Schools
Office of the Board of Education
(732) 946-0055 Ext. 4101
FAX: 732-946-7054

2023-24
Stipend Election Form In-Lieu of Medical Insurance

In accordance with the provisions of the negotiated contract, I have agreed to waive coverage (medical/prescription drug coverage) and opt to receive the stipend in-lieu of this coverage.

I further understand that I may re-enroll in the District's health insurance plan at any time due to a loss of coverage (proof of loss of coverage required) or during the annual open enrollment period.

I certify that I am covered by another health insurance plan and have attached verification of my coverage (**COPY OF CURRENT INSURANCE ID CARD REQUIRED**) offered through:

*Name of Subscriber/Insured: _____

*Subscriber/Insured's Employer: _____

*Medical Plan: _____

I am also declining dental benefits

Date: _____

Signature of Employee

(*REQUIRED INFORMATION)

FOR BOARD OF EDUCATION USE ONLY

Stipend Amount: \$ _____

Effective Date: _____

Comments:

c: Payroll Department

2023-24 School Year Information for Health Care Stipend

*Employee Name			
*Location			
*Date of Hire			
Eligible Dependents (ONLY REQUIRED IF ELIGIBLE FOR FAMILY BENEFITS)			
*Name	*Birth Date	*Social Security No.	*Sex

*** Required fields**

I hereby **AFFIRM** and **ATTEST** that the dependent(s) listed above meets the requirements of eligibility. If any dependent is determined to be ineligible or I fail to notify the Colts Neck Township Schools of a loss of eligibility or any supporting documentation is not provided upon request, I understand that I may be liable for any and all premiums and/or claims paid for any dependent deemed ineligible.

Signature of Employee

COLTS NECK TOWNSHIP BOARD OF EDUCATION

70 CONOVER ROAD • COLTS NECK, N.J. 07722

TEL (732) 946-0055 • FAX (732) 946-7054

TAX EXEMPT #21-6000189

PURCHASE ORDER

THIS NUMBER MUST APPEAR ON ALL PACKAGES, DELIVERY PAPERS, INVOICES, ETC. NOT VALID WITHOUT PURCHASE ORDER NO.

No.

VENDOR

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SHIP TO

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DATE OF ORDER

VENDOR NO.

MEMO

PAYMENT

CHECK DATE

CHECK #

QUANTITY

ITEM & DESCRIPTION

UNIT COST

TOTAL COST

**2023-24 SCHOOL YEAR
STIPEND IN LIEU OF HEALTHCARE COVERAGE**

COVERAGE ELIGIBILITY:

Single _____

Employee/Spouse _____

Parent/Child(ren) _____

Family _____

ACCOUNT NO.

DESCRIPTION

AMOUNT

AN EQUAL EMPLOYMENT & EDUCATIONAL OPPORTUNITY DISTRICT

VENDOR: SIGN AT (X) AND RETURN THIS VOUCHER FOR PAYMENT.

TOTAL THIS ORDER

CERTIFICATION - MUST BE SIGNED

I do solemnly declare and certify under the penalties of the law that the within bill is correct in all its particulars; that the articles have been furnished or services rendered as stated therein; that no bonus has been given or received by any person or persons within the knowledge of this claimant in connection with the above claim; that the amount therein stated is justly due and owing; and that the amount charged is a reasonable one.

BUSINESS ADMINISTRATOR

NO ORDER VALID UNLESS SIGNED BY BUSINESS ADMINISTRATOR

SIGNATURE

POSITION

TAX I.D. NUMBER

VOUCHER COPY - SIGN AT (X) AND RETURN FOR PAYMENT