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

2024-25
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

2024-25 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

SHIP TO

DATE OF ORDER	VENDOR NO.	MEMO	PAYMENT	CHECK DATE	CHECK #

QUANTITY	ITEM & DESCRIPTION	UNIT COST	TOTAL COST
	2024-25 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.

X

SIGNATURE | POSITION | TAX I.D. NUMBER

BUSINESS ADMINISTRATOR

NO ORDER VALID UNLESS SIGNED BY BUSINESS ADMINISTRATOR

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

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