Carle Place Union Free School District
168 Cherry Lane, Carle Place, New York 11514-1788

DECLINATION OF HEALTH INSURANCE
2024-2025 SCHOOL YEAR

I do not wish to enroll, at this time, under any available health insurance plan offered by the District. I understand that such coverage must be forfeited for **one full year*** in order for me to receive a declination payment from the Carle Place School District in the amount delineated in my bargaining unit contract.

* The one full-year period shall be from **September 1, 2024 through August 31, 2025**

ITEMS 1 THRU 5 MUST BE COMPLETED

1. Please check your applicable bargaining unit:

   ☐ Teachers Association ☐ Support Staff ☐ Custodial

   ☐ Administrator ☐ Confidential ☐ Central Office

   ☐ Food Service

2. Please indicate the level of insurance currently selected under your existing (non-school district) health insurance plan. Check all that apply:

   ☐ Self Only ☐ Self and Spouse ☐ Family (Self, Spouse, Dependents)

3. Health Coverage provided through (Employer Name)_____

4. All employees completing this form **MUST** attach a photocopy of their current insurance card to this form.

5. Print Name:_____

   Signature:_____

   Date: _____

New Hires in 2024-2025 Only – Please complete question #6.

6. Date Hired if after September 1st :_____

PLEASE RETURN COMPLETED FORM TO THE PERSONNEL OFFICE BY SEPTEMBER 30, 2024.