



BUSINESS SERVICES
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TO: Employees Represented by FEA, Inc.
FROM: Jason P. Demerath, Director of Business Services
DATE: July 29, 2011
RE: Waiving Health and/or Dental Coverage and Receiving Cash Benefits

This memorandum is directed to all employees who are represented by FEA, Inc. that wish to receive cash compensation in lieu of the group health and/or dental insurance coverage offered by the School District of Fort Atkinson.

Under the 2011-12 collective bargaining agreement, the School District of Fort Atkinson has agreed to provide \$183.75 per month to each employee working half-time or more represented by FEA, Inc. that waives the School District of Fort Atkinson's group health insurance coverage, and \$14.61 per month for waiving the group dental insurance. In order to receive this compensation in lieu of these benefits, *federal regulations require you to prove* you are covered under another health and/or dental insurance plan.

Beginning with the September 2011 payroll, for those eligible employees waiving the School District of Fort Atkinson's group health and/or dental insurance coverage, the School District will add \$183.75 per month to your income for waiving health insurance, and \$14.61 per month for waiving dental insurance, as gross compensation. The monies will be treated as regular taxable wages. Please note that the health insurance amount will be prorated if you are employed less than full-time (1.0 FTE) in the same manner as the premium cost for the insurance would have been. With the transition to two payrolls per month beginning in September, at this point we are planning on splitting that monthly amount between the two paychecks each month.

If you are interested in cash compensation in lieu of the School District's group health and/or dental insurance coverage you must complete the attached form(s). Be sure to attach to the form(s) proof that you are covered under another health and/or dental insurance plan. An example of "proof" is a coverage confirmation letter from the insurance company. If your spouse is an employee of the District and is the primary carrier of the District's coverage, it is still necessary to provide a confirmation that you are covered under your spouse's insurance. We will accept a photocopy (front and back) of your spouse's insurance ID card *that shows your name as covered* with a signed statement on the photocopy stating the following, "I certify that this insurance will provide qualified health (or dental, whichever is appropriate) coverage for me." Return the form(s) and proof(s) of coverage to my attention via interoffice mail to Luther Administration, or to the following address:

Jason P. Demerath
Director of Business Services
School District of Fort Atkinson
201 Park Street
Fort Atkinson, WI 53538

The *deadline for applying* for cash compensation in lieu of the School District of Fort Atkinson's group health and/or dental insurance coverage is **4:00p.m. on August 31, 2011**. If your application is not received in the Business Office by this time you will not be eligible for the benefit until the 2012/13 school year per section 3.12(6)(B) of the 2011-12 collective bargaining agreement. *Please note that an application in transit at the time listed above is not considered received.* Please see the next page for the excerpt from the collective bargaining agreement concerning this benefit. Should you have any questions concerning this matter, please contact me at the address or phone number listed above.

1815 **3.12(6) Cash in Lieu of Insurance (hereinafter “CLI”)**

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1817 **A. Availability**

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1819 Active bargaining unit employees working half-time or more may elect a cash

1820 payment in lieu of (“CLI”) the District’s health and/or dental insurance benefits.

1821 This CLI option shall be available to all bargaining unit members consistent

1822 with any open enrollment periods established by the District.

1823

1824 Note: Absent a “qualifying event” (such as employee marriage, loss of spouse

1825 coverage, etc.), employees who forego enrollment in either the health and/or

1826 dental insurance coverage (at either the point of initial eligibility as a new

1827 District employee or at any point during employment with the District), should

1828 expect to have to prove insurability (i.e., go through health/dental underwriting),

1829 accept restrictions on coverage for pre-existing conditions, or wait for the next

1830 “open enrollment period” in order to enroll at a later date.

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1832 Bargaining unit members shall have the ability to enroll in the health and/or

1833 dental insurance plans when a qualifying event occurs. Upon entry into the

1834 District’s health and/or dental insurance plans, however, that employee’s

1835 participation in the CLI program shall cease.

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1837 **B. Employee Election**

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1839 Prior to September 1 of each year current employees wishing to elect the CLI

1840 benefit for the upcoming school year shall complete a District-provided

1841 application. This application will require proof that the employee is covered

1842 under another health and/or dental insurance plan. Absent a mid-year

1843 (September through August) exception (such as an employee changing to

1844 her/his spouse’s coverage, etc.), employees must make a written annual CLI

1845 election prior to each September 1. When a mid-year exception occurs and an

1846 election is made, payment of the CLI benefit shall begin the month following the

1847 District’s receipt of the election and required proof of other coverage.

1848

1849 **(1) Employee Election for New Employees**

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1851 Payments shall be based on the employee’s eligibility date, which is

1852 the first of the month following the first day worked. Employees not

1853 electing health and/or dental coverage, and those who are not

1854 permitted to elect health and/or dental coverage because they are

1855 married to staff members of the District who have elected health

1856 and/or dental coverage, where eligible, may elect the CLI option no

1857 later than September 1 or their first day of work if after September 1.

1858 Employees who fail to elect the CLI option before September 1 or

1859 their first day of work must wait until the next school year.

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1861 **C. CLI Benefit Amount & Payment**

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1863 The monthly payment amount of the CLI benefit will be equal to forty percent

1864 (40%) of the District’s cost for an individual (not family) health or dental plan

1865 less any applicable payroll expenses (e.g., social security, etc.). For part-time

1866 employees, the cash payment will be prorated in the same manner as the

1867 District’s contribution to the cost of the insurance for individual (not family)

1868 coverage would have been.

1869

1870 **D. Effective Date/Trial Period**



2011 – 2012

BUSINESS OFFICE

CASH IN LIEU OF HEALTH INSURANCE COVERAGE APPLICATION FORM

This form is used to apply for the cash in lieu of the health insurance benefit for those employees represented by FEA, Inc. as outlined in the 2011-12 collective bargaining agreement. Please call Jason P. Demerath, Director of Business Services at 920.563.7800 if you have any questions.

I agree to waive the group health insurance coverage offered by the School District of Fort Atkinson in order to receive cash compensation in lieu of the Employer's group health insurance coverage.

The effective date for my waiver of the group health insurance coverage the Employer provides will be 12:01 a.m. on September 1, 2011 for new employees and 12:00 midnight on September 30, 2011 for employees who currently participate in the District's health insurance plan. I agree that I (and any family members or legal dependents) will not be eligible for reimbursement of my (our) health expenses from the Employer's group health insurance coverage provider that were incurred after the above effective date of my waiver for the Employer's group health insurance coverage. I agree that I (and any family members or legal dependents) will not be eligible for reimbursement of my (our) health expenses from the Employer.

Furthermore, I agree to verify once per plan year that I (and any family members or legal dependents) have health insurance coverage from another source for that plan year. Qualified health insurance coverage is defined by the Employer.

I agree that my election to waive the Employer's group health insurance coverage cannot be changed mid-plan year unless I have a qualified status change. **I further agree that, unless there is an open enrollment period or a qualifying event, I (we) may not be able to join the Employer's group health insurance coverage in the future. If allowed to enroll in the Employer's group health insurance plan (for a reason other than open enrollment or a qualifying event), I (we) may have group health insurance coverage restrictions and/or may have to prove insurability.**

In lieu of the Employer's group health insurance coverage, I elect to receive cash compensation in the amount of \$183.75 per month from the Employer. I agree that the cash compensation is taxable income.

Please check one of the following:

In 2010-2011...

- I had individual health insurance in my name through the District
- I had family health insurance in my name through the District
- I had no health insurance through the District in my name
- I was not employed by the School District of Fort Atkinson (I am a new employee)
- Other (Explain):

EMPLOYEE'S NAME: _____ (please print)

EMPLOYEE'S SIGNATURE: _____ DATE: _____

ADDRESS: _____

WITNESS' NAME: _____ (please print)

WITNESS' SIGNATURE: _____ DATE: _____

BE SURE TO ATTACH PROOF OF QUALIFIED HEALTH INSURANCE FROM ANOTHER SOURCE

2011 – 2012

BUSINESS OFFICE

CASH IN LIEU OF DENTAL INSURANCE COVERAGE APPLICATION FORM

This form is used to apply for the cash in lieu of the dental insurance benefit for those employees represented by FEA, Inc. as outlined in the 2011-12 collective bargaining agreement. Please call Jason P. Demerath, Director of Business Services at 920.563.7800 if you have any questions.

I agree to waive the group dental insurance coverage offered by the School District of Fort Atkinson in order to receive cash compensation in lieu of the Employer's group dental insurance coverage.

The effective date for my waiver of the group dental insurance coverage the Employer provides will be 12:01 a.m. on September 1, 2011 for new employees and 12:00 midnight on September 30, 2011 for employees who currently participate in the District's dental insurance plan. I agree that I (and any family members or legal dependents) will not be eligible for reimbursement of my (our) dental expenses from the Employer's group dental insurance coverage provider that were incurred after the above effective date of my waiver for the Employer's group dental insurance coverage. I agree that I (and any family members or legal dependents) will not be eligible for reimbursement of my (our) dental expenses from the Employer.

Furthermore, I agree to verify once per plan year that I (and any family members or legal dependents) have dental insurance coverage from another source for that plan year. Qualified dental insurance coverage is defined by the Employer.

I agree that my election to waive the Employer's group dental insurance coverage cannot be changed mid-plan year unless I have a qualified status change. **I further agree that, unless there is an open enrollment period or a qualifying event, I (we) may not be able to join the Employer's group dental insurance coverage in the future. If allowed to enroll in the Employer's group dental insurance plan (for a reason other than open enrollment or a qualifying event), I (we) may have group dental insurance coverage restrictions and/or may have to prove insurability.**

In lieu of the Employer's group dental insurance coverage, I elect to receive cash compensation in the amount of \$14.61 per month from the Employer. I agree that the cash compensation is taxable income.

Please check one of the following:

In 2010-2011...

- I had individual dental insurance in my name through the District
 I had family dental insurance in my name through the District
 I had no dental insurance through the District in my name
 I was not employed by the School District of Fort Atkinson (I am a new employee)
 Other (Explain):

EMPLOYEE'S NAME: _____ (please print)

EMPLOYEE'S SIGNATURE: _____ **DATE:** _____

ADDRESS: _____

WITNESS' NAME: _____ (please print)

WITNESS' SIGNATURE: _____ **DATE:** _____

BE SURE TO ATTACH PROOF OF QUALIFIED DENTAL INSURANCE FROM ANOTHER SOURCE