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# TRAVERSE CITY AREA PUBLIC SCHOOLS

## Cash-In-Lieu Election Form & Compensation Agreement Change Form

**PLAN YEAR:**  
**Effective Date:**

Employee Name:

Employee Number:

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### ELECTION to Receive a CASH-IN-LIEU OF INSURANCE Benefit

- x I am eligible for but elect not to participate in the TRAVERSE CITY AREA PUBLIC SCHOOLS (TCAPS) HEALTH BENEFIT PLAN. I understand and acknowledge that this election is null and void unless I furnish TCAPS with adequate proof that I am currently covered by other medical insurance (i.e. a copy of my current medical insurance identification card or other proof that is acceptable). Once TCAPS accepts my proof of other medical insurance coverage,

**I understand that TCAPS will increase my taxable compensation by \$ \_\_\_\_\_ per month in lieu of my taking health insurance benefits.** This will typically be paid in the first paycheck of the calendar month.

Because I am declining enrollment for myself (and any eligible dependents) due to other medical insurance coverage, I understand that I may, in the future, be able to enroll myself (and eligible dependents) in this medical plan, provided that I request enrollment within 30 days after my other coverage ends. In addition, if I have a new dependent as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependents, provided that I request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

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By signing this agreement, I agree to adhere to the terms of applicable bargaining or employee group contracts. I understand that I must be actively covered under a medical insurance plan to receive a monthly Cash In Lieu benefit. It is my responsibility to notify TCAPS if my coverage ends or is suspended for any reason, and that any collection of Cash In Lieu while not covered under a medical plan is in direct violation of applicable bargaining or employee group contracts. This violation could result in the repayment of funds paid not in compliance with applicable bargaining or employee group contacts.

\_\_\_\_\_  
Employee Signature

Date: \_\_\_\_\_

\_\_\_\_\_  
Employer Signature: Employee Benefits Office

Date: \_\_\_\_\_

\*A copy of your current medical card must accompany this form.