



Cash in Lieu of Health Insurance Coverage Form

I agree to waive the group health insurance coverage offered by the St. Croix Falls School District to receive cash compensation. This agreement is in effect for the Plan Year beginning September 1, 2026.

I agree that I and all members of my "tax family" will not be eligible for reimbursement of our health expenses from the Employer's group health insurance coverage provider. For purposes of this form, my "tax family" includes all individuals for whom I expect to claim a personal exemption deduction for the 2026 and 2027 tax years.

Furthermore, I attest that my tax family has or will have health insurance coverage under another health insurance plan during the Plan Year beginning September 1^o, 2026. I also attest that the other health insurance plan provides Minimum Essential Coverage (MEC) and is not an individual health insurance plan.

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 Event.

In lieu of the Employer's group health insurance coverage, I elect to receive cash compensation per the terms of the employee handbook. I agree that the cash compensation is taxable income.

I further agree that if the St. Croix Falls School District knows that I or a member of my tax family does or will not have other health insurance plan coverage during the Plan Year beginning September 1, 2026, it will not pay me any cash compensation for my waiver of group health insurance coverage.

Employee Name (Please Print) _____

Employee Signature: _____

Date: _____