WAIVER OF HEALTH INSURANCE BENEFITS
and
RELEASE OF CLAIMS AGAINST THE
DISTRICT/ASSOCIATION

THIS AGREEMENT, entered into by and between:

THE KARNS CITY AREA SCHOOL DISTRICT,
hereinafter "District,"

and

THE KARNS CITY AREA EDUCATION ASSOCIATION,
PSEA/NEA,
and
THE KARNS CITY ESPA-PSEA-NEA
hereinafter "Association,"

and

_____,
a full-time employee of the Karns City Area School District.

WHEREAS, the parties have negotiated an agreement permitting employees to elect to receive financial compensation in lieu of the District's providing hospitalization and major medical insurance; and

WHEREAS, the negotiated Collective Bargaining Agreement requires the employee to execute a waiver and release of claims against the District and the Association.

NOW, THEREFORE, in consideration of the payment contemplated by this Agreement and intending to be legally bound, the undersigned full-time employee having fully read the provisions of this Agreement does hereby agree as follows, to-wit:

I.

I understand that I hereby choose not to participate in the negotiated health insurance plans and coverages established through the Western Pennsylvania Schools Health Care Consortium. I understand that I shall be paid an amount agreed to in the current Collective Bargaining Agreement, and that payment shall be made by the last paycheck in June of each year. I further understand that I am entitled to reinstate the health benefits only in the event of an emergency (i.e., death of spouse), at the earliest possible date as permitted by the carrier.

Knowing and understanding the above, I hereby elect not to participate in or utilize the negotiated health insurance plans and coverage established through the Western Pennsylvania Schools Health Care Consortium. I do further, on behalf of myself, my heirs, executors, administrators and assigns, release the District and the Association from all claims, losses, or actions which may result from the signing of this Waiver.

II.

I further understand that as a result of the signing of this waiver and release, I may not have health insurance coverage. YOU ARE ADVISED TO REVIEW ANY OTHER APPLICABLE COVERAGE OR POLICIES OF HEALTH INSURANCE TO DETERMINE THE EFFECT, IF ANY, OF THIS WAIVER AND RELEASE WITH REGARD TO ANY OTHER COVERAGES. THE DISTRICT MAKES NO REPRESENTATION AS TO WHETHER OTHER COVERAGE WILL OR WILL NOT BE IN EFFECT.

INTENDING to be legally bound, I hereunto set my hand and seal to this Waiver of Health Insurance Benefits and Release of Claims, this _____ day of _____, 20___.

READ CAREFULLY BEFORE SIGNING.

_____
Employee Name (Please print)

_____
Employee Signature

_____
Employee Social Security No.