Return Date: May 20, 2016

WAIVER OF MEDICAL/HOSPITAL INSURANCE
BATTLE CREEK PUBLIC SCHOOLS
CAFETERIA PLAN

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1. Introduction.

I, the undersigned, am an Employee of the Battle Creek Public Schools (the "Employer").

In accordance with the terms of my employment with the Employer, and the Battle Creek Public Schools Cafeteria Plan (the "Plan"), I have elected to waive coverage for myself and my dependents under all medical/hospital insurance programs of the Employer. My waiver is knowing and voluntary. Under the terms of the Plan, the terms of my employment, and this Agreement, the Employer is willing to permit me to waive medical/hospital insurance coverage under the employer's health insurance program.

2. Waiver of Participation.

In Accordance with the Plan, I, for myself and my heirs, assigns, successors, spouse and dependents, hereby waive any right on my part and the part of my spouse and dependents to participate in any and all medical/hospital insurance programs maintained by the Employer. For purposes of this waiver, "medical/hospital insurance programs" shall not include insurance coverage that may be available to me for dental, vision, or life. In making this knowing and voluntary waiver, I, on behalf of myself and my spouse and dependents, understand and agree that we will have no coverage or benefits whatsoever under any of the Employer's medical/hospital insurance programs, and that this waiver may not be revoked, except to the extent permitted under the Plan in the event of a change in family status. My waiver of medical/hospital insurance is effective only for the first Plan year after the date of this Waiver (or within which this Waiver is executed, if the signing person has become eligible to participate in the Plan on a date other than the first day of a Plan Year). If my spouse is an Employee of the Employer, this Waiver does not affect my spouse's right to receive benefits under the Plan, in accordance with the terms of my spouse's employment with the Employer.

3. Release and Indemnification.

I, for myself and my heirs, assigns, successors, spouse and dependents, covenant and agree that I will not make any claim under any of the Employer's medical/hospital insurance programs for medical expenses that I incur during the Plan Year that this Waiver is in effect (even if I receive bills for those expenses after the end of the Plan Year), and I fully release the Employer, the Administrator, and all agents of each of them, and all insurers under policies maintained by the Employer from providing me medical/hospital insurance coverage during the Plan Year, from any liability arising in connection with any claim by me, or my spouse, or dependents during the Plan Year, or for any benefits coverage during the Plan Year under any of the Employer's medical/hospital insurance programs; and I, for myself and my heirs, assigns, successors, spouse and dependents, agree to defend and indemnify the Employer, the Administrator, and all agents of each of them, from any liability, loss, damages, costs or expenses

(including but not limited to attorneys fees) arising in connection with this Agreement, or any claim for benefits or coverage under any of the Employer's medical/hospital insurance programs.

4. **Acknowledgments.**

Except in the case of a change in family status, as defined in the Plan, I acknowledge and agree that my election to enter into this agreement and waive coverage under the Employer's medical/hospital insurance programs is: (i) irrevocable during the Plan Year for which it is made; (ii) knowing and voluntary; and (iii) with full understanding of all the provisions of this Agreement.

5. Tax Consequences.

The Employer, as to any possible tax, has made no representations to me consequences of this Agreement and the Employer shall have no liability with regard to any such tax consequences. I am not relying on the Employer for any tax advice.

6. Applicable Law.

This agreement will be construed in accordance with the laws of the State of Michigan.

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Return Date: May 20, 2016

Please complete and return to Human Resources. This option must be signed up for annually. Failure to return this waiver will result in the loss of this benefit.

_____	_____	_____
EMP. ID#	Printed Name	Signature

_____	_____
Telephone #	Date

Note: You may elect to contribute this payment to a 403(b) or 457 plan. In order to do so, a salary reduction agreement must also be completed. Please contact the payroll office at (269)965-9508 or (269) 965-9509 with any questions.