

A. Name _____ Social Security No. _____

B. Please check the reason you are completing this form:

- Open Enrollment
- New Employee
- Change in Family Status
- Spouse of covered employee

C. Payment Method

- I elect to continue to participate in the medical plan
- I elect to waive the Medical Plan and receive cash to be paid in two (2) equal installments (the second pay in June and the second pay in December) to a total of \$1,250 for the year for single plan-opt and \$1,750 for the year for two party or family coverage opt-out.
- I have previously elected not to participate in the medical plan and would like to receive cash in two (2) equal installments (the second pay in June and the second pay in December) to a total of \$1,250 for the year single plan and \$1,750 for two party or family opt-out.

D. Evidence of Other Coverage (not needed for spouse who is opting out)

If you are waiving Medical Plan coverage, please complete the following inquiry about your replacement coverage and attach proof of other health insurance (**copy of enrollment information or ID card**):

Insurer/Plan _____ Policy # _____
Plan Sponsor (e.g. Employer) _____
Spouse's Social Security Number (if applicable) _____

E. Important Information - Please Read Carefully

I understand:

Application to opt out or opt back in will be made during the month of November of each school year.

New Employees will notify the business office as soon as possible prior to employment. If a new employee opts out of participation in a district health plan he/she will be entitled to a pro rated stipend of the \$1,250 or \$1,750 times (# months divided by 12) for the remaining months to be paid on the next scheduled payment date.

I cannot change these benefit elections or compensation agreement as of any date prior to the next Plan Year unless I have a change in family status (i.e., marriage, divorce, birth or adoption of a child), or changes in spouse's employment and such other events as the Plan Administrator determines will permit a change.

Prior to the end of the Period of this election and each election period thereafter, I will be offered the opportunity to change my election for the following year. If I do not complete and return a new election form at that time, I will be treated as having elected to continue my benefit coverage that is in effect for the current Plan Year.

In **emergency situations, and loss of benefits elsewhere**, an employee will be able to immediately notify the district of his/her intent to opt back into the PPO program. If an employee opts to return in an emergency situation and has been paid the part of the full bonus of \$1,250 or \$1,750 to opt out, the bonus will be pro rated at 1/12th for each month of health benefits that weren't used.

Employee's Signature

Date Signed