# PLEASANT HILL SCHOOL DISTRICT #1
# OPT-OUT FORM: EMPLOYEE HEALTH INSURANCE PLAN

Name of Employee (please print): _____ Plan Year: _____

In accordance with the participation requirements for OEBB opt-out provisions, and Pleasant Hill School District #1 association agreements, members who elect not to participate in a medical plan will be entitled to receive a monthly financial incentive. **Incentives will be paid as taxable income.** The District will continue to pay any employer sponsored policies per contract language.

## Terms and Conditions

**I fully understand and certify the following:**

1. To be eligible to opt out of the OEBB-sponsored Health Insurance Plan I must maintain coverage under another comprehensive employer-sponsored group medical benefit plan.
2. The election to opt out of the Health Insurance Plan is entirely voluntary. Pleasant Hill School District is not responsible for any expenses incurred after my insurance termination date for my dependents or myself. Furthermore, my covered dependents and I are not eligible for COBRA continuation coverage.
3. Elections to opt out of the health benefit plans must be made at the time of hire, when initially meeting eligibility or during the annual open enrollment period.
4. If, at a later date, I wish to re-enroll as a member of the Pleasant Hill School District's health plans, I understand I will no longer be eligible for the monthly financial incentive. I also understand I may enroll in the district's benefit plans during the next open enrollment unless current coverage ends prior to that event.
5. Coverage for previously OEBB-eligible employees or a previously OEBB-eligible dependent enrolling in the dental and/or vision plans during an open enrollment period will be limited to routine and preventive care for the first 12 months.
6. I agree to return to Pleasant Hill School District all payments made in error or for fraudulent acts which include, but are not limited to, the following: (a) failure to report change and/or Qualifying Changes in Status timely; (b) falsifying information in order to receive opt out Incentive payments.
7. I understand that if I become ineligible for the financial incentive due to the loss of other coverage, I must re-enroll in the OEBB Health Plan within 30 days of loss of coverage or wait until the next open enrollment period.

I certify I am covered under another comprehensive employer-sponsored group medical benefit plan and I wish to opt out from the following:

- ☐ Medical
- ☐ Dental
- ☐ Vision

**Signature of Employee:** _____ **Date:** _____

Attach Proof of Other Group Insurance Coverage

Other coverage Subscriber Name: _____
(Spouse, parent, or partner name)

⌦ Return completed form, with proof of insurance, to Payroll.
⌦ Logon to OEBB and indicate your election to opt-out (if this is a change & when open enrollment is required).