

HERMON-DEKALB CENTRAL SCHOOL

709 East DeKalb Road
 DeKalb Junction, NY 13630
 Phones: (315) 347-4920 Fax: (315) 347-3817

Employee Benefits Division
 2020 - 2021 Opt out Attestation Form

EMPLOYEE INFORMATION

Name		Social Security Number	Negotiating Unit NON-UNION	
Street Address		City	State	Zip
Date of Birth	Telephone Number	Marital Status	<input type="checkbox"/> Single <input type="checkbox"/> Separated	Marital Status Date
		<input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		

HERMON-DEKALB CENTRAL SCHOOL HEALTH BENEFITS OPT-OUT ELECTION

Complete this section if you are newly eligible or annually, if currently eligible/enrolled in St. Law.-Lewis Health Ins. Plan

Employees must attest below that they are covered under other employer-sponsored group health insurance coverage other than St. Law.-Lewis Health Ins. Plan as of the opt out effective date, to be eligible for the Opt-out Program.

- I am electing to opt out of single coverage in exchange for a \$1,500 taxable amount.
 I am electing to opt out of two person coverage in exchange for a \$2,500 taxable amount.
 I am electing to opt out of family coverage in exchange for a \$3,500 taxable amount.

Other employer-sponsored group health insurance information(must be provided)

Name of covered employee _____ Covered Employee's date of Birth _____

Covered Employee's SSN _____ Covered Employee's Employer _____

Effective Date of alternate health insurance coverage _____

Name and address of alternate health insurance coverage _____

**ATTESTATION**

All employees complete this section

I attest to the following:

- I am covered under another employer-sponsored group health plan other than St. Law.-Lewis HIP that is in effect as of the opt out effective date and have provided my alternate plan information
- I understand that I must promptly report changes to information I have provided above which may impact my eligibility
- I understand that this election is for the 2019 - 2020 school year only.
- I meet the qualifications to elect the Health Insurance Opt-out Program at the tier selected above.

Employee's Signature _____ Date _____

Employees who can demonstrate and attest to having other employer-sponsored group health insurance may elect to opt out of St. Law.-Lewis Health Ins. Plan. Employees who elect to opt-out of the St. Law.-Lewis Health Ins. Plan will receive \$1,500, \$2,500, or \$3,500 taxable for waiving Single, Two-Person, or Family coverage respectively. In order to participate, employees must have other employer-sponsored group health insurance, other than St. Law.-Lewis Health Ins. Plan.

There are two circumstances when employees may elect to opt out of coverage; as newly eligible for coverage, and annually, for currently eligible/enrolled employees, during the Annual opt-out period in June. Only employees who experience a qualifying event will be allowed to withdraw their Opt-out election and enroll in a health insurance plan mid-year. Such withdrawal may result in forfeiture of any payment due the employee.

INSTRUCTIONS:

Newly eligible employees: Employees may enroll in the Opt-out Program no later than their first date of St. Law.-Lewis Health Ins. Plan eligibility. Employees must sign the Health Insurance Opt-out Attestation Form or complete a St. Law.-Lewis Health Ins. Plan Enrollment Card.

Currently Eligible Enrollees: Eligible enrollees may elect the Opt-out Program during the Annual Opt-out Period in June for each plan year. Employees must sign the Health Insurance Opt-out Attestation Form.

During Mid-Year: Employees who experience a Qualifying Event must notify the Business Office within thirty(30) days of the Qualifying Event date in order to enroll in a health insurance plan. Employees must complete a health insurance enrollment card

By signing the Opt-out Attestation, you elect to receive \$1,500, \$2,500, or \$3,500 , this amount will be paid in accordance with the contract.