OPT OUT FLEX HEALTH INSURANCE DEDUCTIONS FORM

Please complete this form only if you want to **opt out** of pre-tax health deductions.

Employee Name:_____

School Assignment:_____

Payroll Type: ☐ Teacher ☐Admin/Classified ☐Custodian

Certification:

My signature below certifies I do NOT wish to enroll in the flexible benefit plan for my health insurance premium and that:

1. I am aware that premium and other contributions made under this plan are the property of my employer and will be used to purchase the elected coverage and cannot be refunded.
2. I understand this agreement cannot be changed during the plan year unless I experience a qualifying event.
3. This agreement cannot be revoked during the plan year.

Signature:_____ Date: _____