STATE COLLEGE AREA SCHOOL DISTRICT
ELECTION TO DECLINE HEALTH INSURANCE COVERAGE

I, _____, hereby decline health insurance coverage under the State College
(Print Name)
Area School District Premium Conversion Plan. I fully understand that if I do not maintain enrollment in a health insurance program, I am at risk for generating uninsured medical claims and I hold the District harmless for such claims.

Proof of other insurance:

Name of Policy Holder: _____

Employer of Policy Holder: _____

Group #_____ **ID #** _____

Name of Insurance Company: _____

Please attach a copy of your insurance card to this form.

Upon presentation of proof of other insurance coverage, the District will provide you up to $2,000.00 per year. Payments will be made in two installments, in December and June. The amount will be pro-rated based on the date of the opt-out. No incentive will be provided to an employee who is covered as a dependent on another District employee's insurance.

If you lose the health insurance coverage referenced above, you have 30 days to notify the Human Resources Office of such change. The Human Resources Office needs to be notified in writing of this and all Family Status changes within 30 days of when the change occurred. Failure to notify the Human Resources Office in a timely manner will bar you from making a change until the next annual open enrollment period.

My signature below indicates that the facts set forth on this form are true and complete to the best of my knowledge. I also understand that if my group health insurance status changes, it is my responsibility to notify the Human Resources Office in writing within 30 days of such change.

Name (Please Print):_____
Signature: _____ **Date:** _____
Employee #: _____

For Human Resources Office use only

Effective Date _____ Date Received _____

☐ Pro-rate # Months _____ Amount $_____

Processed by: _____