# Opt Out Form
## Employee Health Insurance Plan
### Rogue River School District
### Certified Employee

Certified employees are eligible to receive a $250 monthly stipend if they opt out of the district's health insurance package (medical, dental, vision, and FSA/HSA). To be eligible for the opt-out incentive, a full-time employee must certify that they have other qualifying comprehensive medical insurance.

Employee Name: _____

Current Insurance Carrier: _____

Insurance was obtained through:_____

**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 plan, or be enrolled in Medicare or TriCare, in accordance with OAR 111-040-0050 and the collective bargaining agreement.
2. The following types of coverage are NOT eligible for the medical opt-out incentive: Oregon Health Plan (Medicaid), Veteran's Administration program, student health plans, coverage bought on the individual market. If you have questions about this contact the Business Office.
3. The election to opt out of the health insurance plan is entirely voluntary. Rogue River 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.
4. 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.
5. If I elect to opt out of the Health plan, I will continue to be enrolled in the mandatory employer-paid basic life and long term disability plans. I understand I am eligible to participate in the optional supplemental life and disability insurance plans, which includes employee and dependent coverage options.
6. To receive the financial incentive, I must opt out of the medical, dental, and vision insurance plans.
7. If, at a later date, I wish to re-enroll as a member of the district's health plans, I understand I will no longer be eligible for the opt-out 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.
8. Coverage for previously OEBB-eligible employees or a previously OEBB-eligible dependent enrolling in the dental plans during an open enrollment period will be limited to routine and preventive care for the first 12 months.
9. I agree to return to Rogue River 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.
10. 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.
11. I understand that the opt-out incentive will immediately end if it is ever not allowed by law or if it jeopardizes the tax-free status of the District's insurance contribution.
12. This incentive amount is subject to applicable payroll taxes.

**I certify that I am covered under another qualifying comprehensive employer-sponsored group medical benefit plan. I wish to opt out from the OEBB medical, dental, vision, and FSA/HSA package.**

**Member Signature:**_____ **Date:**_____/_____/_____

**Send completed form to the Business Office. Also, log onto the OEBB benefits enrollment system and indicate your election to opt out (click the little gray o/o button), or fill out a paper OEBB Open Enrollment form with your opt-out choice selected.**