

Coquille School District #8

**Opt-Out Form: Employee Health Insurance Plan**

In accordance with the participation requirements for OEGB opt-out provisions, and Coquille School District CBA's, members who elect not to participate in the OEGB Health Plan including medical, dental, and vision coverage will be entitled to receive a monthly financial incentive.

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

1. To be eligible to opt-out of the OEGB 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. Coquille 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 an annual open enrollment period.
4. If I elect to opt-out, I am entitled to receive either a monthly stipend or a payment into a district approved Sec125, 403B or 457 plan in accordance with the MOU for my union.
5. 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 monthly stipend. I also understand I may only enroll in the district's benefit plans during the next open enrollment unless my current coverage ends prior to that event.
6. I agree to return to Coquille 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 OEGB 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.

I am opting for a monthly stipend.                      OR                       I am opting for a monthly payment into a district approved 403B/457B.

- ✓ Attach Proof of Insurance
- ✓ Return completed form with proof of insurance to Carrie Blanton (payroll).
- ✓ Logon to the OEGB on-line benefits system and indicate your election to opt out.

\_\_\_\_\_  
**Member Name**

\_\_\_\_\_  
**Date**

Office Use Only:

Proof of Insurance Attached

Ins. Carrier: \_\_\_\_\_

Termed from OEGB as of: \_\_\_\_\_