

GROUP HEALTH INSURANCE PLAN OPT-OUT NOTIFICATION

I, _____, hereby elect **not** to be covered by the Copley-Fairlawn
PRINT NAME HERE
City School District's group health plan for the 2025–2026 school year. I have health care coverage under another insurance plan.

I elect to receive a payment of \$750.00 in lieu of health coverage according to the provisions of Article 15.05 OPT-OUT of the CTA Negotiated Agreement. This payment will be included in the first payroll in September 2026.

Employee Signature

Date