

## 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 10: WAGES AND BENEFITS, Section I: OPT-OUT of the CSS Negotiated Agreement.

This payment will be included in the first payroll in September 2026.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date