MURRIETA VALLEY UNIFIED SCHOOL DISTRICT

Opt-Out of Medical Health Care Coverage

Employee Name: _____ SSN: _____

Position: _____ Date of Hire: _____

I am eligible to participate in the medical health care program provided by MVUSD. I have been offered the opportunity to participate in the MVUSD health care program and have chosen to decline to enroll as I have other health care coverage.

Name of policy holder: _____

(Employer): _____

Insurance Company: _____

Policy Number: _____

Please provide proof of coverage

I understand that by declining to enroll at this time I will not be able to establish coverage except at the regular open enrollment periods as designated by MVUSD. Exception: Some changes regarding my employment status (example: change from part time to full time) may qualify me for eligibility prior to the regular open enrollment period. I also understand that I can continue to keep vision and dental coverage at no cost to me.

Employee Signature: _____ Date:

Return this form to Benefits in Risk Management

District representative: _____ Date: _____