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 2026–2027 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 2027.

____ ______________________
Employee Signature Date