

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

This payment will be included in the first payroll in September 2027.

Employee Signature

Date