



REJECTION OF MEDICAL INSURANCE COVERAGE

EMPLOYEE NAME: _____

EMPLOYEE ID#: _____

- [] I am rejecting medical health insurance coverage at this time. I understand that I will **not** be eligible to request coverage until the annual Open Enrollment period in the month of July/August each year with coverage beginning October 1st of that year.

Upon rejection of coverage, the only exception to enrollment at any other time other than the annual Open Enrollment period is if there is a qualifying event listed below:

- Loss of other coverage due to divorce
- A change in the employee's employment status or a change in the employment status of the individual through whom the employee and dependent(s) were previously covered as a dependent
- The **involuntary** termination of the other plan under which the employee or the employee's dependent(s) were previously covered as a dependent
- The cessation of an employer's contribution toward an employee's dependent coverage
- The death of a person through whom the employee or an employee's dependent(s) were previously covered as a dependent

• Part Time Employee's Pro-Rate of District Contribution • (Payroll Contributions paid per month for 10 months: September – June)				
Hours worked by Employee	Contribution	Basic Plan		Plan B
5 Hours or more but less than 6	25%	\$442.62		\$500.22
4 Hours or more but less than 5	50%	\$885.24		\$942.84
3 Hours or more but less than 4	75%	\$1,327.86		\$1,385.46

Signature of Employee

Date