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**OPT-OUT ELECTION FORM**

We recommend eligible employees review enrollment materials whether electing benefits, keeping benefits the same, making changes, or waiving enrollment. The elections you make will remain in effect until the end of the plan year unless you experience a life change event.

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| 1. **EMPLOYEE INFORMATION** |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **First Name** | **Initial** | **Last Name** | **Social Security** | **Birth Date** | **Gender** |
|  |  |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Street Address** | **Unit** | **City** | **State** | **Zip** |
|  |  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Email Address** | **Phone** | **Position** | **Location** |
|  |  |  |  |

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| 1. **OPT-OUT PAYMENT (Proof of employer sponsored medical insurance required** |

**YOU WILL NOT QUALIFY FOR A CASH OPT-OUT IF**

* The election form and required documents are not submitted by the enrollment deadline.
* You have enrolled in Medicare, Medicaid, Chip or Cobra insurance.
* Your spouse is an employee of the William Penn School District.
* You are covered as a dependent on another plan.
* You had previously received the Opt-out and later re-enrolled in district insurance.

**REASONS FOR FORFEITURE OF CASH OPT-OUT**

* Re-enrollment into a district medical insurance plan.
* Employment separation during benefit period.

**PRORATED PAYMENTS**

* New hire enrollment subject to proration according to hire date.
* Life change event
* Unpaid leave of absence

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Relationship** | **First Name** | **Last Name** | **SSN** | **Birth Date** | **Gender** |
| **WPSD employee** |  |  |  |  |  |
| **Subscriber/**  **Spouse** |  |  |  |  |  |
| **Dependent** |  |  |  |  |  |
| **Dependent** |  |  |  |  |  |
| **Dependent** |  |  |  |  |  |
| **Dependent** |  |  |  |  |  |

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| 1. **OPT-OUT AGREEMENT OF TERMS** |

I understand that I am eligible for coverage through my employer. I DO NOT want coverage for myself or any of my dependents. I have read the enrollment information and understand that my signature indicates I agree with the terms as written.

**Sign and return to Human Resources with all required documents.**

**Employee Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Human Resources: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**