OSEA Opt Out Form: Employee Health Insurance Plan

Ashland School District

In accordance with the participation requirements for OSEA-Ashland Chapter Association agreement, members who elect not to participate in the ASD Health Plan including medical, pharmacy, dental, and vision coverage will be entitled to receive a monthly financial incentive.

Member Name: ________________________________ **Employee SSN/ID#:** _____________________

I fully understand and certify the following:

1. To be eligible to opt out of the ASD-sponsored Health Insurance Plan I must maintain coverage under another group medical benefit plan.
2. The election to opt out of the Health Insurance Plan is entirely voluntary. Ashland School District is not responsible for any expenses incurred after my insurance termination date for my dependents or myself. Furthermore, my covered dependents and I are not eligible for COBRA continuation coverage.
3. Elections to opt out of the health benefit plans must be made at the time of hire, when initially meeting eligibility or during the annual open enrollment period.
4. If I elect to opt out, I am entitled to receive a flat dollar amount of $200 per month.
5. If I elect to opt out, I will continue to be enrolled in the ASD-paid basic life, AD&D and long term disability plans if applicable.
6. If, at a later date, I wish to re-enroll as a member of the ASD's health plans, I understand I will no longer be eligible for the monthly financial incentive. I also understand I may enroll in the district's benefit plans during the next open enrollment or a qualifying event, unless current coverage ends prior to that event.
7. I agree to return to ASD all payments made in error or for fraudulent acts which include, but are not limited to the following: (a) failure to report change and/or Qualifying Changes in Status timely; (b) falsifying information in order to receive opt out Incentive payments.
8. I understand that if I become ineligible for the financial incentive due to the loss of other coverage, I must re-enroll in the ASD Health Plan within 30 days of loss of coverage or wait until the next open enrollment period.

- **I certify I am covered under another comprehensive employer-sponsored group medical benefit plan and I wish to opt out from the following ASD Health Plans: ☐ Medical ☐ Dental ☐ Vision**

Member Signature: ____ **Date:** ______/______/_________

Proof of Insurance: Medical Policy: #___________________________ **Insurer:** ___________________

✓ **Send completed form to ASD - Human Resources, 885 Siskiyou Blvd, Ashland, OR 97520.**

HR Use Only	Monthly Opt Out Incentive Amount: $_____________ Effective: _____/_____/_____	2018-19