### <u>Bellmore-Merrick CHSD</u> <u>Heath Insurance OPT-Out Election Form</u> 2017 Plan Year

Г	<u>2017 Plan Year</u>								
					oloyee's DOB:				
Em	ployee's SS	#:	•	• J	ob Title/Buildi	ng	1		
			Ba	rgaining Unit	(circle or cheo	ck one):			
Adn	ninistrators	Teachers		dial/Cafeteria	Clerical	Paraprofessionals	Non-Unit		
	(Unit I)	(Unit II)		(Unit III)	(Unit IV)	(Unit V)	Employees		
I he						red by the Bellmore Me			
	Schoo	l District (I	<i>VYSHIP/E</i>			HIP Prime HMO II) as	follows:		
				Chec	k only one:				
	I am electing	g to opt-ou	t of <b>indivi</b>	dual coverage					
	I am electing to opt-out of <b>family</b> coverage. I understand that I may choose to opt out of family coverage only if I have eligible dependents. ( <b>Please complete dependent information below</b> .)								
	I am enrolling/enrolled in the District's (circle one: NYSHIP/EMPIRE, HIP Prime HMO I, HIP Prime HMO II) group health insurance plan for myself but I am opting out of <b>family coverage for my dependents</b> . ( <b>Please complete dependent information below</b> .)								
			My d	ependents' in	formation is a	s follows:			
	Last Name	Fir	st Name	Relationship	Date of Birth	Addre			
	Last Manie	<u><u> </u></u>		Kelationship		<u>Autro </u>			
A marriage certificate or a birth certificate must be submitted to the Personnel Office for your dependent(s). If you have already submitted a copy you do not need to resubmit.									
Please read and check off all boxes below:									
					<b>. . .</b>				
	I hereby att	est that I a	Pleas	se read and ch	neck off all box	es below:	nce plan that is not		
			<b>Pleas</b> m and/or	<b>se read and ch</b> my eligible dep	<b>eck off all box</b> bendents are cov				
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Insurance plans offered by the District. <u>*PLEASE TURN OVER AND COMPLETE ACA WAIVER FORM</u> <i>⇒*</u>

For Personnel Use Only:					
Effective Date:	Payroll:	NYSHIP:	B/O List:	DOH:	

## Bellmore-Merrick CHSD Office of Personnel & Administration

# AFFORDABLE CARE ACT (ACA) WAIVER

Employee Name:

Date:

Plan Year:

**201**7

# Please Check ONE: I waive enrollment in my employer's NYSHIP/EMPIRE, HIP Prime HMO I, and HIP Prime HMO II group health insurance plans for myself (INDIVIDUAL). I waive enrollment in my employer's NYSHIP/EMPIRE, HIP Prime HMO I, and HIP Prime HMO II group health insurance plans for myself AND my dependents (FAMILY). I am enrolling/enrolled in my employer's (circle one: NYSHIP/EMPIRE, HIP Prime HMO I, HIP Prime HMO I, HIP Prime HMO II) group health insurance plan for myself but I am waiving coverage for my dependents (ENROLLING/ENROLLED IN INDIVIDUAL, OPTING OUT OF FAMILY FOR DEPENDENTS).

Reason for Waiving- Please check ONE:				
	I am covered through my spouse's employer OR			
	I am covered through my former employer's retiree health insurance plan OR			
	I am covered through a parent's employer OR			
	Other. Please Explain:			

# *I understand that I am waiving coverage in my employer's* NYSHIP/EMPIRE, HIP Prime HMO I, and HIP Prime HMO II *group health insurance plans as noted above*.

Employee Signature:

Date: \_\_\_\_

Date:

Personnel			
Signature:			
C			