Bellmore-Merrick CHSD
Heath Insurance OPT-Out Election Form
2016 Plan Year

Employee's Name:	
Employee's Social Security #:	
Job Title:	
Building:	

Bargaining Unit (circle or check one):					
Administrators (Unit I) ☐	Teachers (Unit II) ☐	Custodial/Cafeteria (Unit III) ☐	Clerical (Unit IV) ☐	Paraprofessionals (Unit V) ☐	Non-Unit Employees ☐

I hereby elect to opt-out of the health insurance plans presently offered by the Bellmore Merrick Central High School District (NYSHIP/EMPIRE, HIP Prime HMO I and, HIP Prime HMO II) as follows:

Check only one:	
☐	I am electing to opt-out of **individual** coverage
☐	I am electing to opt-out of **family** coverage. I understand that I may choose to opt out of family coverage only if I have eligible dependents. (**Please complete dependent information below**.)
☐	I am enrolling 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 **family coverage for my dependents**. (**Please complete dependent information below**.)

My dependents' information is as follows:

Last Name	First Name	Relationship	Date of Birth	Address

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:	
☐	I hereby attest that I am and/or my eligible dependents are covered by a health insurance plan that is in effect as of the date I opt-out of the health insurance plans offered by the District.
☐	With this form, I have submitted a copy of my current health insurance card and my dependents health insurance card as proof that I and/or my eligible dependents are covered by a health insurance plan as of the date of this opt-out election.
☐	I understand that this election is for the **2016 plan year** only. In order to enroll in the opt-out program for the 2017 plan year, I must again submit an opt-out election form during the open enrollment period for the 2017 plan year. *(Open Enrollment Period is October 14 through December 31)*
☐	I understand that by declining to enroll in the District's health insurance program at this time I may subject myself and/or my eligible dependents to certain applicable waiting periods if I decide to enroll at a later date.
☐	I understand that by declining to enroll in the District's health insurance program at this time I may be forfeiting my right to such coverage after my retirement.
☐	I understand that the District cannot be held responsible for any claims that arise during the time my eligible dependents and I are not covered by the District's health insurance plan due to my election to participate in one of the aforementioned opt-out programs.

***To be eligible for the opt-out program, employees must: (1) be covered by a health insurance plan (through a spouse, parent, other employer, etc.); and (2) submit proof of such coverage to the District. (Regardless of which opt-out program you chose you must submit proof of coverage for yourself and your dependents). A copy of your health card is sufficient proof of coverage.**

_____ _____

Employee's Signature Date

Affordable Care Act (ACA) Waiver Form must also be completed if you are electing to opt-out of the health insurance plans offered by the District. PLEASE TURN OVER AND COMPLETE.

Bellmore-Merrick CHSD
Office of Personnel & Administration

AFFORDABLE CARE ACT (ACA) WAIVER

Employee Name: _____

Date: _____

Plan Year: **2016**

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 in my employer's (circle one: NYSHIP/EMPIRE, HIP Prime HMO I, HIP Prime HMO II) group health insurance plan for myself but I am waiving coverage for my dependents **(ENROLLING 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: _____

Personnel Signature: _____ Date: _____