Bellmore-Merrick CHSD
Heath Insurance OPT-Out Election Form
2019 Plan Year

Employee's Name:			
Job Title:		**Building**	

☐ Check here if you are a **NEW HIRE** (entire form must still be completed)
☐ Check here if you are an **ACTIVE EMPLOYEE** and there is **NO CHANGE** to your buyout (entire form must still be completed)
☐ Check here if you are an **ACTIVE EMPLOYEE** and there is a **CHANGE** to your buyout (entire form must still be completed)
☐ Check here if you are an **ACTIVE EMPLOYEE** and you are ***COMING OFF*** **Health Insurance** (entire form must still be completed)

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) in ***accordance with the collective bargaining agreement***.

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/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 **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 AND List name of your insurance carrier:

☐	I hereby attest that I am and/or my eligible dependents are covered by a health insurance plan that is not coverage in the individual market (whether or not obtained in the insurance Marketplace) that is in effect as of the date I opt-out of the health insurance plans offered by the District and through the 2019 plan year.
☐	With this form, I have submitted a copy of my current health insurance card and my dependent's 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. **NAME OF INSURANCE CARRIER**:_____
☐	I understand that this election is for the **2019 plan year** only. In order to enroll in the opt-out program for the 2020 plan year, I must again submit an opt-out election form during the open enrollment period for the 2020 plan year. *(Open Enrollment Period is November 1 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 insurance card for you and your dependent(s) is considered proof of coverage.

_____ _____
Employee's Signature Date

In addition, an 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.
Do not forget to submit a copy of your health insurance card for you and all your dependents.

For Personnel Use Only: OE ☐/NH ☐/QLE ☐
Effective Date: _____ Payroll: _____ NYSHIP: _____ B/O List: _____ DOH: _____