Full Time Classified Opt Out Form
Employee Health Insurance Plan
Sweet Home School District

In accordance with the participation requirements for OEBB opt-out provisions, OAR 111-040-0050 and Sweet Home School District's association agreements, classified employees eligible for one hundred percent of the district insurance contribution who elect not to participate in the OEBB Health Plan including medical/pharmacy, dental and vision coverage will be entitled to receive a monthly financial incentive.

Employee Name: _____

I fully understand and certify the following:

1. To be eligible to opt out of the OEBB-sponsored Health Insurance Plan I must maintain coverage under another comprehensive employer-sponsored group medical benefit plan. Other group coverage **does not include** Medicare, Medicaid, Veterans Administration Health Benefits, student health benefits, the federal health exchange, a state health exchange or an individual pla
2. The election to opt out of the Health Insurance Plan is entirely voluntary. Sweet Home 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 monthly amount of **$200.**
5. If I elect to opt out of the medical, dental and vision plans, I will continue to be enrolled in the District paid basic life and mandatory long-term disability plans. I understand I am eligible to participate in the voluntary Life, Long Term Care plan(s).
6. I must notify the District if my other coverage ends and I understand I will no longer be eligible for the monthly financial incentive. I will be eligible to re-enroll in coverage through the District provided qualifying event requirements established by the insurance company are met.
7. I understand that if I become ineligible for the financial incentive due to the loss of other coverage, I must re-enroll in the OEBB Health Plan within 30 days of loss of coverage or wait until the next open enrollment period.
8. Coverage for previously OEBB-eligible employees or a previously OEBB-eligible dependent enrolling in the dental and/or vision plans during an open enrollment period will be limited to routine and preventive care for the first 12 months.
9. I agree to return to Sweet Home School District 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.
10. I understand that the opt-out incentive will immediately end if it is ever not allowed by law or if it jeopardizes the tax free status of the District's insurance contribution.
11. This incentive amount is subject to applicable taxes.
12. **I must provide the District with proof of other employer group coverage.**

I certify that I am covered under another comprehensive employer-sponsored group medical benefit plan and I wish to opt out from the OEBB medical, dental and vision plans.

Member Signature: _____Date: _____/_____/_____

To opt out, send completed form and proof of other medical coverage to Amanda Hill in the Business Office. You must also, login to myOEBB and indicate your election to opt out at open enrollment.

Office Use Only
Monthly Opt Out Incentive Amount: $_____ Effective:_____