LEE COUNTY HEALTH PLAN "OPT-OUT" ENROLLMENT FORM

Lee County Board of County Commissioners

Name (Last, First, MI): _____ SS#: xxx-xx-_____

(Please print) *(Required)*

Effective Date of Enrollment:_____ Dept: _____

BoCC employees may not participate in the Opt-Out plan, if they are covered by another Lee County or covered entity plan.

By signing this agreement, I understand all aspects of this plan as they have been presented to me, and agree to all the terms of this benefit.

- Enrollment in this plan takes effect for all new employees when all other benefits become active. Existing employees can *ONLY* enroll during open enrollment that becomes effective on January 1 of the next plan year. ***You must present proof of your other insurance to qualify.***

- While enrolled in this plan, I will not be eligible to rejoin the Lee County Health Plan until the next annual open enrollment period benefits become effective on January 1st of the following plan year. ***Unless*** I experience a qualifying event, that allows re-enrollment, as defined in the Lee County's Health Plan documents.

- I am responsible for reporting to Human Resources any change in my health insurance *status within 60 days of the date of any qualifying event* which would allow me to rejoin the Lee County Health Plan. This is done by submitting an enrollment and change form with the appropriate documents attached (i.e., proof of loss of health insurance coverage, etc.). If I do not contact Human Resources to report an event within the specified time limit, I will NOT be eligible to rejoin the health plan until the next open enrollment period.

- Should I experience a qualifying event during the plan year and rejoin the Lee County Health Plan, I will not be eligible for re-enrollment in the Opt-Out benefit, regardless of my health insurance status, until the next open enrollment period.

- In order to re-enroll once I have cancelled the "Opt-Out Plan", I must present proof of other insurance coverage to re-qualify for the plan during open enrollment as well as provide a new written waiver of coverage.

Note: Once enrolled, participation will automatically "roll over" into each succeeding plan year unless the employee has rejoined the health plan. ***Rejoining the health plan at any time will automatically STOP the opt-out benefit payment.***

Employee Signature:_____ Date: _____