



HEALTH CARE INSURANCE OPT OUT ELECTION FORM

Name: _____

Employee ID: _____

TO OPT OUT OF EMPLOYER-SPONSORED HEALTH CARE INSURANCE COVERAGE:

1. Complete and sign this form. This form may be completed electronically and printed for signature.
2. Complete an **Enrollment / Change of Status Form** and provide appropriate proof of relationship for all dependents that could have been covered under the health plan (unless previously provided).
3. Provide documented proof of medical coverage under another group health plan. Proof of other coverage should be in the form of a letter or form from the other employer, retirement system or insurance company verifying medical coverage. Copies of insurance cards are NOT acceptable.

OPT OUT PROGRAM GENERAL PROVISIONS:

1. Healthcare opt out elections will become effective on the first of the month following receipt of the appropriate forms and documentation as described in section above. Coverage for participants currently enrolled in a medical plan through Wayne County or the Wayne County Courts will be cancelled at that same time.
2. This election is **irrevocable** once submitted and may not be changed until the next open enrollment period *unless* proof of loss of medical insurance is provided to Benefits Administration within thirty (30) days of the loss. Those eligible to re-enroll under these circumstances will be placed in the County's plan of choice until the next open enrollment period.
3. Payment of earnings under this program will only occur for those months which the employee was eligible for healthcare benefits. If payment of earnings is to be paid on an annual basis, payment will be prorated based on the number of months eligible during the year (beginning with October) for which the employee elects to opt out if less than twelve (12) months. If payment of the opt out earning is made in advance and the employee becomes ineligible for benefits during the year for which the earning was paid, the employee will be responsible for reimbursing the employer the prorated amount for the months during which the employee was ineligible for coverage.
4. Payment of any earnings due to opting out of healthcare coverage is subject to appropriate taxes unless a Health Care Reimbursement account has been established by the County and elected by the employee.

OPT OUT ELECTIONS:

Employee Group	Earning Amount	Method of Payment
All Employee Groups	15% of average annual medical & prescription drug premium of PPO & HMO plans based on coverage tier (single, two or family)*	Paid as a lump-sum earning in <u>arrears</u> (during month of October)*

* Refer to published benefit summaries or opt out earning schedules for specific earning amounts; amount of earning may be prorated based on the number of months during which employee was actually eligible for healthcare coverage during the preceding plan year if less than 12 months. For the amount available currently applicable, please check the County benefits website ([click here](#)).

Check the box next to each healthcare plan type listed below for which you elect to opt out.

Medical & Rx Dental Vision

NOTE: Unless otherwise specified by your labor agreement or benefit plan, opting out of medical coverage does not require that you opt out of dental and/or vision benefits. You may choose to waive these benefits, but no earning will be accrued to you for doing so.

I have read and understand the above conditions and procedures for opting out of healthcare coverage and agree to them in making my election to opt out of the employer-sponsored group medical, dental and/or vision plan coverage made available to me.

Signature: _____

Date: _____

Return all forms and documentation to Cornerstone Municipal
50 W. Big Beaver Rd., Ste. 220, Troy, MI 48084
Fax: 248-878-2127 or Email: waynecountybenefits@cmuni.us
For questions or additional information, please call 888-989-8686 or email waynecountybenefits@cmuni.us