BELLFLOWER UNIFIED SCHOOL DISTRICT

MEDICAL INSURANCE "OPT-OUT" PLAN 1

2016-2017 PLAN YEAR ELECTION FORM

I, _____, hereby acknowledge that I am currently covered
(Print Name)
as either a subscriber or dependent on a medical insurance plan enabling me to participate in the "Opt-Out" Program.

By participating in the "Opt-Out" Plan 1, I fully understand that once this election is made I will be unable to participate in the medical insurance benefits during the plan year unless there is a qualifying event. A qualifying event means loss of the other coverage, change in legal marital status or termination of employment.

I also understand that I must re-enroll in the "Opt-Out" Plan at open-enrollment each.

I also wish to Opt out of Dental & Vision plans ☐ Yes ☐ No (you must mark yes or no)

_____ _____
Signature Date

_____ _____
Printed Name Marital Status

_____ _____
Home Phone Number Social Security #

_____

_____
Mailing address, including city, state and zip code

_____
Home Email address

NOTE: Incomplete forms will NOT be accepted. <u>This is the ONLY form the District will accept – do NOT submit older forms</u>.