Opt Out Form: Employer MCSIG/Blue Cross Health Insurance Plan

Cuesta Community College

Effective July 1, 2015, current members who elect not to participate in the Cuesta College Health coverage will be entitled to receive a monthly financial incentive to be used toward voluntary plans offered by the District.

Member Name: _____ **Banner ID#** _____

Employee Group: _____ **Classified** _____ **Management**

I fully understand and certify the following:

1. To be eligible to opt out of the Cuesta College Health coverage I must maintain coverage under another medical benefit plan and provide proof to the Cuesta College Insurance/Benefits Office.
2. The election to opt out of the Health Insurance Plan is entirely voluntary. Cuesta Community College 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 during the open enrollment period only (unless I have a qualifying event).
4. All Classified employees who opt out, are entitled to receive up to the amount of $225 per month which can be spent on the districts approved plans (Dental, Vision, AFA Policies, Health Savings Account, Flexible Spending Account, AFLAC Policies, Investments, Life Insurance and Accidental Death and Dismemberment). Any unused portion will be forfeited and returned to District.
5. All Management employees who elect to opt out, are entitled to receive up to the amount of $265 per month which can be spent on the districts approved plans (Dental, Vision, AFA Policies, Health Savings Account, Flexible Spending Account, AFLAC Policies, Investments, Life Insurance and Accidental Death and Dismemberment). Any unused portion will be forfeited and returned to District.
6. If, at a later date, I wish to re-enroll as a member of the College's health plans, I understand I will receive the current fringe amount I qualify for per the CCCUE Article 4 Bargaining Agreement. I also understand I may enroll in the college's benefit plans during the next open enrollment unless my current coverage ends prior to that event.
7. I agree to return to Cuesta Community College 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.
8. I understand that if I become ineligible for the financial incentive due to the loss of other coverage, I must re-enroll in the Cuesta College Health coverage within 30 days of loss of coverage or wait until the next open enrollment period.

- **I certify I am covered under another medical benefit plan and I wish to opt out from the following Cuesta College plans: ❑ Medical**

Member Signature: _____Date: _____/_____/_____

Proof of Insurance: Medical Policy: #_____ Insurer: _____

- ✓ **Send completed form to Benefits Office, SLO Campus Room 8003**
- ✓ **Send copy of current proof of insurance (Online print-out, carrier coverage letter)**

Benefits Office Use Only	Proof of other coverage received: _____	Monthly Opt Out Incentive Amount: $_____ Effective: _____/_____/_____