Opt-Out Election Form

This is to acknowledge that I have been given the opportunity to enroll in Saucon Valley School District medical/prescription/dental/vision plans. I am choosing the waive this coverage under the following provisions:

Employees who are enrolled in healthcare benefit coverage under the District medical plan and discontinue District-provided coverage at any time by providing proof of coverage elsewhere shall receive a recurring bonus payment of $1,000 each school year. The bonus payment shall be paid across all pays of the school year. Married spouses who both work for the District shall not be eligible for the payment. Employees shall receive this full bonus so long as they remain off the plan for a full year. In the event an employee leaves or returns to the District plan during the year the payment herein shall be prorated based on when the employee left or returned to the District plan.

Employees may re-enroll in the plan under two circumstances:

- *a qualifying life event as defined by the District's benefits plan*
- *at the next regularly scheduled open enrollment.*

If such Employees later wish to re-enroll in a District paid medical plan they may do so at open enrollment and without a penalty.

Precise terms and conditions of all group insurance benefits shall be described by the master plan or master contract issued by the carrier.

Date: _____

Signature of Employee: _____

Print Name: _____

Proof of Insurance

Please provide proof of insurance for you and/or your dependents. Please list where you and/or your dependents are covered and provide copies of insurance cards

Insurance Carrier: _____

Policy Number: _____

Employer: _____