Opt Out Election Form

This is to acknowledge that I have been given the opportunity to enroll in Saucon Valley School District medical/rx/dental/vision plans. I am choosing to waive this coverage for the $1000 Opt Out bonus and understand that I will not be eligible to enroll in Saucon Valley School District medical/rx/dental/vision plan for 1 year as per the current Collective Bargaining Agreement. If I choose to enroll after receiving the Opt Out bonus, I will be responsible for 25% of the total cost of the plan for the first 12 months.

Date:_____

Signature of employee: _____

Print Name: _____

Note: Employee is asked to complete the following

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:	