Health Insurance Opt-Out Agreement

I have been given an opportunity to fully participate in the group medical plans provided by The Escambia County Board of County Commissioners. The benefits of the plans have been thoroughly explained to me and I decline to participate.

2. I understand that I may re-enroll into the plan only during an annual Open Enrollment period as determined by The Escambia County Board of County Commissioners or during a "special enrollment period" within thirty (30) days of a qualifying event. Qualifying events are described in the Escambia County Employee Benefit Plan Documents.

3. I understand that I MUST provide proof of other Group Health coverage (ex. Copy of Medical ID Card, Letter from insurance company that demonstrates current coverage) for all members of my tax family (dependents on my tax return) that have or are expected to have minimum essential coverage (MEC) for the plan year along with this completed form to the Benefits Department by the required deadline. Other Group Health coverage cannot be the result of my spouse's or parent's employment relationship through a BCC-sponsored plan. Entities that participate in BCC-sponsored plans include the Escambia Clerk of Circuit Court and Comptroller, the Escambia County Housing Finance Authority, the Escambia County Human Relations Council, the Escambia Property Appraiser, the Escambia County Supervisor of Elections, the Escambia County Tax Collector, and the Santa Rosa Island Authority. Failure to submit the required documentation will result in an automatic enrollment into a **non-paid** Medical Opt-Out plan and I will not receive the $2400 annual Opt-Out Payment.

4. Upon the timely receipt of this completed form and supporting documentation, I understand my request will take effect January 1st following the end of the current year's Open Enrollment period; or the first day of the following month (unless otherwise stated) from the receipt of this form by the Benefits Department for a "Qualifying Event/Change in Status" request outside the Open Enrollment period. For new hires, the Opt-Out Payment will start the 1st day of the month following 30 days of employment, if eligible, and if the Benefits Department has received an executed Health Insurance Opt-Out Agreement.

5. I understand that I will receive $2400 annually, prorated as appropriate, dispersed in $100 increments in the first two paychecks pf each month, in accordance with the payroll cycle, i.e. the expected total payment is $200 each month that I am employed for the full month. The payment is considered taxable income and will be treated accordingly.

6. I will also be eligible for the Health Insurance Replacement (HIR) Plan. This plan provides $10,000.00 additional life insurance for a total of $50,000.00 basic life insurance paid by the County and a dental discount of $12.98 per month on any dental coverage.

7. **I am not currently covered by TRICARE or Medicare.** Employees that are TRICARE participants and employees who are eligible for Medicare will not be eligible for the benefit due to prohibitions of such payments by the Department of Defense and the Centers for Medicare and Medicaid Services, respectively.

8. I understand that the continuation of the "Opt-Out" Program is subject to periodic review and/or adjustment or discontinuation.

9. I understand that participants who chose to "opt-out" must actively re-enroll in the "Opt-Out" Program and provide supporting documentation each year during open enrollment.

I have read, understood, and agree to comply with the requirements stated above.

_____ _____

Employee Signature **Date**

_____ _____

Please Print Your Full Legal Name **Employee ID #**

Return this agreement along with your proof of other insurance coverage to benefits@myescambia.com