THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA

Benefits & Employment Services INSPIRING A NEW WAVE OF EDUCATORS & EMPLOYEES

MEDICAL OPT-OUT AFFIDAVIT FORM

NOTE: YOU MAY ONLY OPT-OUT OF YOUR MEDICAL PLAN (OUTSIDE OF OPEN ENROLLMENT) IF YOU ARE NOT CONTRIBUTING ANY PRE-TAX PREMIUMS.

1. I have been given an opportunity to fully participate in the group medical plans provided by The School Board of Broward County, Florida. 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 determine by The School Board of Broward County, FL or during a "special enrollment period" (Change in Status). A "special enrollment period" is a period of time during which you may be able to elect to enroll yourself and/or dependent (s) after one of the following events occurs:
   - **Loss of other medical insurance coverage** – You may be able to enroll yourself and/or your dependent (s) provided that you request enrollment within **thirty (30) days** after such other coverage ends. In the case of COBRA continuation coverage, you may be eligible for a special enrollment period if the COBRA coverage is exhausted. A special enrollment period is not available if coverage under your prior plan or COBRA coverage was terminated for failure to timely pay the required premiums.

     Internal Revenue Service (IRS) guidelines state that the loss of coverage through an individual health plan does not constitute a valid "Change in Status" event.
   - **Acquiring a new dependent** – If you acquire a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and/or your dependent (s) provided that you request enrollment within **thirty (30) days** after the date of marriage, birth, adoption or placement for adoption.
3. I understand that I **MUST provide proof of other Group Health coverage** (ex. Copy of Medical ID Card, Letter from insurance company) along with this completed form to the Benefits Department by the required deadline. 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 $750 annual Opt-Out Supplement**.
4. Upon the **timely** receipt of this completed form and supporting documentation, I understand my request will take effective **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 "Change in Status" request outside the Open Enrollment period, whichever is applicable. I also understand the I will receive $750 annually/prorated, dispersed in each paycheck in accordance with my payroll cycle.
5. I have read, understood and agree to comply with the requirements stated above.

Employee Name (Print): _____

Employee Signature: _____

Date: _____ Personnel No.: _____

Daytime Phone Number: _____

Please Select One (1):

This is an Open Enrollment election ☐

This is a Change in Status Request ☐
(Outside the Open Enrollment Period)

Return form along with your proof of other insurance to:
The Benefits Department
Please **DO NOT** send by Pony
Email to: optout@browardschools.com or **Fax to**: 754-321-3280
(The above email account is to be used **only** during the **Open Enrollment period**. Otherwise, please send documents to the above fax number or email to: **Benefits@browardschools.com**)

OFFICE USE ONLY

Effective Date: _____

SS#: _____

By: _____