|  |
| --- |
| **EMPLOYEE INFORMATION** |
| Employee Name: | SS #: |
| Home Address: | City | State | Zip Code |

 I elect **NOT** to participate in the medical insurance program.

This non-participation entitles me to compensation in the amount of $1,500, payable in the last pay period of June and reported as employee income, per the Collective Bargaining Agreement 2017-2022, Section 9.1-4. **Please attach proof of coverage to this form.**

**MEDICAL ELECTION**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **HD1/HC1 w/ Integrated Prescription Drug (Please Circle one)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Employee | Employee/Child | Employee/Children | Employee/Spouse | Family |
| $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |

 |

**DENTAL AND VISION**

 I elect **NOT** to participate in dental coverage I elect **NOT** to participate in vision coverage

|  |
| --- |
| **DENTAL PER PAY DEDUCTION** |
|  Employee | $1.00 |
|  Employee/Dependents | $2.50 |

|  |
| --- |
| **VISION PER PAY DEDUCTION** |
|  Employee | $.50 |
|  Employee/Dependents | $1.00 |

**Please provide the following information for individuals (including yourself) who will be covered by any of the health benefits elected above. \*\* Please attach a copy of a marriage license if adding spouse and birth certificates if adding children.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Last Name | First Name | Date of Birth | Gender | Social Security # |
| You |  |  |  |  |  |
| Spouse |  |  |  |  |  |
| Child |  |  |  |  |  |
| Child |  |  |  |  |  |
| Child |  |  |  |  |  |
| Child |  |  |  |  |  |
| Child |  |  |  |  |  |

**I REQUEST BENEFITS UNDER THE GROUP COVERAGE INDICATED ABOVE AND AUTHORIZE DEDUCTIONS FROM MY EARNINGS OF ANY REQUIRED CONTRIBUTIONS FOR ANY SUCH COVERAGE.**

**EMPLOYEE SIGNATURE** **DATE**

**RETURN COMPLETED FORM TO THE PERSONNEL OFFICE**