MERCY GENERAL HEALTH PARTNERS
Medical Insurance
OPT-OUT ELECTION FORM

Name: ______________________________

Social Security Number: ______________________________

Budgeted Hours Per Pay Period: ______________________________

I elect to opt out of medical coverage offered to me by Mercy General Health Partners. I understand that I **must be insured by another medical plan** to choose the Opt Out option and receive Opt Out dollars. I will verify my other medical coverage below and agree to notify the Human Resources Department of any changes to this information.

MEDICAL PLAN COVERAGE VERIFICATION

Name of Policyholder/Subscriber: ______________________________

Policyholder's Social Security Number: ______________________________

Group Contract Number: ______________________________

Name of Insurance Company: ______________________________

Employer of Group Plan: ______________________________

Date Coverage Begins: ______________________________

AUTHORIZATION

I understand that, by signing and submitting this form, I am making a binding election. I realize that this election cannot be changed during the plan year, until the next enrollment period unless I experience a qualified change in family status. I may rejoin the medical plan through Mercy General Health Partners if I have a family status change (i.e. birth, death, divorce, loss of coverage due to termination of employment or employment change) by applying for coverage within 30 days of the event: or I may rejoin at the annual open enrollment period. I understand that Mercy General Health Partners accepts no responsibility or liability for my waiver of coverage.

I understand and agree that this form is to be completed and returned to Human Resources upon eligibility and that I am responsible to check my pay stub to verify that my opt out dollars are included after this election. I understand that if this form is not received within 30 days of eligibility or if I do not report that my opt out dollars are not included in my check within 30 days of eligibility that I will forfeit this opt out election until the next open enrollment period.

______________________________ ______________________________

EMPLOYEE SIGNATURE **DATE**

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For Human Resources Use Only:

Effective Date: ______________ **Initial:** ______________

[illegible] MedOptOut
[illegible]