Human Resources
& Risk Management
COUNTY OF IMPERIAL

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Director of Human Resources &
Risk Management

RETIREE MEDICAL PLAN OPT-OUT FORM

Complete if you, your spouse/domestic partner and/or dependent(s) are declining County of Imperial Medical plan coverage.

Last Name: _____ First Name: _____ Social Security # _____

Address: _____ Phone Number: _____

Specific enrollment rules for retirees prevent re-enrollment into the County health plan once a retiree has waived coverage including retiree, spouse/domestic partner and dependents. **This does not apply to retirees who have waived benefits that have another group health coverage, proof of enrollment is required.**

I am opting out coverage for:

☐ Myself: (Name) _____ ☐ Spouse/Domestic partner: _____

☐ Dependent: (Name) _____ ☐ Dependent: (Name) _____

By signing this form, I acknowledge that:

- I do not wish to participate in the County of Imperial Health plan as stated above.
- Once I decline health coverage or my dependent's coverage I cannot re-enroll or have my dependent re-enroll in the County of Imperial Retiree Medical Plan at a later date.

Reason for Declining Coverage:

☐ Covered by another **group** health plan (e.g., through your spouse/domestic partner employer's health plan)
Carrier Name: _____ ID or Medicare Number: _____

☐ Covered by an **individual** health plan.
Carrier Name: _____ ID or Medicare Number: _____

☐ Other: (Please explain) _____

Attention - Please sign and date - I verify that the information provided by me is accurate and complete.

_____
Signature Date