Human Resources
& Risk Management
COUNTY OF IMPERIAL

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