



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:	
coverage including retire		nt into the County health plan once a retiree has waived pendents. *This does not apply to retirees who have waived enrollment is required.
I am opting out coverag	e for:	
Myself: (Name)		Spouse/Domestic partner:
Dependent: (Name))	_ Dependent: (Name)
Once I declin	n to participate in the County of Impose health coverage or my dependent he County of Imperial Retiree Medius	nt's coverage I cannot re-enroll or have my dependent
Reason for Declining Co	overage:	
		gh your spouse/domestic partner employer's health plan) ID or Medicare Number:
Covered by an in	ndividual health plan.	
Carrier Nam	e:	ID or Medicare Number:
Other: (Please ex	xplain)	
Attention - Please sig	n and date - I verify that the infor	rmation provided by me is accurate and complete.
Signature		Date