

**Wayne County Benefit Administration Division  
REDUCTION IN HEALTH CARE BENEFIT  
HEALTH CARE INSURANCE OPT OUT ELECTION FORM**

*Use this form if you are a Third Circuit Court employee and a member of AFSCME and wish to opt out of health care benefits*

**Name:**

**Employee ID:**

You may decline employer-sponsored medical coverage and receive a bi-weekly cash rebate equal to twenty percent (20%) of the average premiums paid of all existing premiums in the employee's coverage tier (single person, two person or family). Premiums renew on October 1<sup>st</sup> of each year.

**TO OPT OUT OF EMPLOYER-SPONSORED HEALTH CARE INSURANCE COVERAGE:**

1. Application must be made to the Wayne County Benefit Administration Division using this form.
2. You must complete an **Enrollment/Change of Status Form** and provide proof of relationship for your dependents unless provided previously.
3. Documented proof of other, outside medical insurance must be provided at the time application is made. The Benefit Administration Division shall determine the appropriate level of documentation necessary to satisfy this provision.
4. Your current coverage under that plan will be cancelled the first of the month following receipt of the appropriate forms and documentation.
5. This election is **irrevocable** once submitted and may not be changed until the next open enrollment period unless proof of loss of medical insurance is provided to Benefit Administration within thirty (30) days of the loss. Those eligible to re-enroll under these circumstances, will be placed in the Community Blue PPO plan.
6. Payment is subject to appropriate taxes unless a Health Care Reimbursement account has been established by the County and elected by the employee.
7. Your bi-weekly opt out earning will begin with the pay that includes the 1<sup>st</sup> of the month in which your medical opt out begins.

**OPT OUT ELECTIONS:**

Place your initials in the box next to each health care plan listed below for which you wish to opt out.

**Medical (including prescription drugs)**

**Dental**

**Vision**

***I have read and understand the above conditions and procedures for opting out of medical coverage and agree to them in making my election to opt out of medical coverage.***

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

*Return all forms and documentation to the Wayne County Benefit Administration Division located at 600 Randolph, Room 171, Detroit, MI 48226. For questions or additional information, please call (313) 224-2004*