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 GAA and wish to opt out of health care benefits

Name: **Employee ID:**

You may decline employer-sponsored medical coverage and receive an annual, lump sum cash rebate of $950 as specified under the terms and conditions of your labor agreement.

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. If you currently have Wayne County-sponsored medical coverage, you must complete an ***Enrollment/Change of Status Form*** for the plan in which you are enrolled in order to cancel coverage for you and your family.
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. If you are currently enrolled in a Wayne County employee medical plan, your current coverage 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 Blue Preferred 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 1st of the month in which your medical opt out begins.
8. Opting out of medical coverage does not require that you opt of dental and/or optical reimbursement benefits. You may, however, choose to waive these benefits. **There is no cash rebate associated with opting out of these benefits.** IF YOU CHOOSE TO WAIVE DENTAL AND/OR OPTICAL BENEFITS, please place your initials in the box next to the following statement.

☐ **I choose to waive my employer-sponsored dental benefits.**

☐ **I choose to waive my employer-sponsored vision benefits.**

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

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