2020 OPEN ENROLLMENT OPT OUT FORM

EFFECTIVE DATE:	12 / 16 / 2019
RECEIVED BY:	
ENTRY DATE: ENTERED BY:	

OPEN ENROLLMENT OPT OUT FORM AND SUPPORTING DOCUMENTS ARE DUE TO HUMAN RESOURCES EMPLOYEE BENEFITS DIVISION BY 5:00 PM ON NOVEMBER 27, 2019.

Email: HRBenefits@fresnocountyca.gov **Phone:** (559) 600 - 1810 **Fax:** (559) 455 - 4787

USPS Mail Address & Hand-Delivery Location: 2220 Tulare Street, 14th Floor, Fresno, CA 93721

EMPLOYEE INFORMATION: *Complete all information*

Last Name:____________________ First Name:____________________ Employee ID:____________

SSN:____________________ DOB:________________ Phone Number:____________________

Email Address:____

Employer Providing Other Coverage:____

PLEASE CHECK ONE:

☐ **Ongoing Opt Out Request** ☐ **New Opt Out Request**

To opt out of the County's health insurance coverage for the 2020 plan year, you must have other qualifying employer-sponsored group health coverage.

Please read each item below carefully:

- I understand that this election is irrevocable once submitted and I can only re-enroll myself and my dependent(s) if I experience one of two specific situations:
    1. I have lost other health insurance coverage and must provide written proof from the insurance company to Employee Benefits **within thirty (30) days** of the termination date of said coverage.
    2. During the annual Open Enrollment period.
- I understand that I must provide **current, written proof of other employer-sponsored* group health coverage** as well as this completed request to Employee Benefits. Proof is subject to approval by Employee Benefits staff.
- I understand that I am opting out of the entire County health insurance coverage, which includes: medical, dental, vision, prescription, and mental health coverage.
- I understand that since I am electing not to participate in County health insurance coverage, I will not be eligible for the $10,000 Basic County-paid Life and AD&D insurance policy.
- I understand that in order to continue my opt out status each plan year, I am **required to resubmit** the Opt Out Form, along with current, written proof of other employer-sponsored group health coverage **every year** during the annual Open Enrollment period. I also understand that failure to resubmit during that time will result in me being automatically assigned into employee only health insurance coverage as follows: Anthem Blue Cross HDPPO 3000 with DeltaCare USA DHMO dental coverage.
- I certify that by not electing to participate in the County of Fresno's health insurance coverage, I am currently not subject to any court order or legal obligation to provide health insurance for my dependent(s).

*Exception – Employees under the age of 26 may opt out with proof they are covered under a parent's medical insurance policy.

✕ SIGNATURE: ______________________________ **DATE:** ____________

My signature confirms that I understand and agree to all conditions and procedures listed above for opting out of County of Fresno health insurance coverage for Plan Year 2020.