OAK PARK SCHOOL DISTRICT

13900 Granzon • Oak Park, MI 48237
www.oakparkschools.org

Election or Waiver of Health Insurance

(Premium Contribution or Cash in Lieu)

Employee: _____
Last, *First* *Middle Initial*

Address: _____
Street *Apt #*

_____
City *State* *ZIP*

Date of Birth: ____ / ____ / _____ Social Security number: _____ - _____ - _____

☐ I **elect** to receive Oak Park School District ("OPSD") medical insurance. By doing so, I agree to complete enrollment forms within 30 days of hire. I further elect to reduce my salary on a pre-tax basis to pay my required share of insurance premiums. This amount will be deducted on a regular basis through normal payroll beginning with the designated plan year.

☐ I **waive** receiving OPSD medical insurance. By doing so, I will receive additional, taxable compensation (cash in lieu). This amount will be determined under the applicable collective agreement/individual contract, and paid to me on my normal payroll schedule.

To be eligible for cash in lieu, I must first provide proof of other qualifying group medical insurance **for myself and each member of my expected tax family** (all individuals on my tax return). A copy of an insurance card is not acceptable (although Canadian citizens may provide a copy of the OHIP card). Proof is an official document verifying insurance under a group health insurance plan. For example, a letter or official website document from your spouse's employer stating your family is currently covered under its health insurance plan, and which lists your family members' names as eligible dependents.

Your other medical coverage cannot be government-provided insurance (e.g., Medicare, Medicaid, Tricare, VA, MIChild), COBRA, or any plan purchased as an individual, including those purchased through the Health Insurance Marketplace.

☐ I **refuse** to enroll myself in any type of medical coverage at this time, and I am aware of the possible consequences under the ACA. By declining affordable coverage, I will not receive Marketplace premium subsidies, nor will I receive cash in lieu.

I acknowledge:

1. My election can't be changed during the plan year, unless for a qualifying event.
2. My next opportunity to obtain coverage will be during the Annual Open Enrollment period.
3. If I declined coverage, I will not be eligible for COBRA continuation if my employment ends during the period of coverage I have declined.

_____ _____
Employee Signature *Date*