2019-2020

Opt-Out Form: Employee Health Insurance Plan

Clackamas Community College

In accordance with the participation requirements for OEBB opt-out provisions, OAR 111-040-0050 and Clackamas Community College association agreements, qualifying members who elect not to participate in the OEBB Health Plan including medical, pharmacy, dental, and vision coverage will be entitled to receive a monthly financial incentive.

Member Name: _____ **Employee ID#** _____

Employee Group: _____ **Admin/Conf** _____ **Full Time Classified** _____ **Full Time Faculty** _____ **Part Time Faculty**

I fully understand and certify the following:

1. To be eligible to opt out of the OEBB-sponsored Health Insurance Plan I must maintain coverage under another comprehensive employer-sponsored group medical benefit plan.
2. The election to opt out of the Health Insurance Plan is entirely voluntary. Clackamas Community College is not responsible for any expenses incurred after my insurance termination date for my dependents or myself. Furthermore, my covered dependents and I are not eligible for COBRA continuation coverage.
3. Elections to opt out of the health benefit plans must be made at the time of hire, when initially meeting eligibility or during the annual open enrollment period (October 1st).
4. If I elect to opt out (of all medical, dental and vision plans), I am entitled to receive a flat dollar amount of $200 per month (*Administrative, Full Time Classified, and Full-Time Faculty Only*).
5. Employees who work .75 FTE or less shall be entitled to a pro-rated amount stated in #4.
6. If I elect to opt out, I will continue to be enrolled in the College-paid basic life, AD&D and long term disability plans if applicable.
7. If, at a later date, I wish to re-enroll as a member of the College's health plans, I understand I will no longer be eligible for the monthly financial incentive. I also understand I may enroll in the college's benefit plans during the next open enrollment unless current coverage ends prior to that event.
8. I agree to return to CCC all payments made in error or for fraudulent acts which include, but are not limited to the following: (a) failure to report change and/or Qualifying Changes in Status timely; (b) falsifying information in order to receive opt out Incentive payments.
9. I understand that if I become ineligible for the financial incentive due to the loss of other coverage, I must re-enroll in the OEBB Health Plan within 30 days of loss of coverage or wait until the next open enrollment period.

I certify I am covered under another comprehensive employer-sponsored group medical benefit plan and I wish to opt out from the following OEBB Health Plans: ❑ Medical ❑ Dental ❑ Vision

Member Signature: _____Date: _____/_____/_____

Proof of Insurance: Medical Policy: #_____ Insurer: _____

- ✓ **Submit completed form to Human Resources, Barlow 204, 19600 Molalla Avenue, Oregon City, OR 97045.**
- ✓ **Also, log onto the OEBB online benefits system and indicate your election to opt out.**

HR Use Only	Monthly Opt Out Incentive Amount: $_____ Effective: _____/_____/_____	*Admin/Confidential, Full Time Faculty and Full Time Classified are only eligible for stipend benefit.*