EMPLOYEE BENEFITS DEPARTMENT

Human Capital Management

Office of Management and Enterprise Services

2401 N. Lincoln Blvd., Oklahoma City, OK 73105
405-522-5528 or 800-219-8115

Employee Opt-Out Acceptance

I, _____ , understand that I am opting out of the Basic Plan of Benefits (Health, Dental, Disability and Basic Life); or, I may retain my Life and Disability Benefits by opting out of Health and Dental Only:

☐ Basic Plan (Health, Dental, Disability and Basic Life)

☐ Health and Dental only

By opting out of the above benefits, I understand that I will not receive the state-provided benefit allowance I would otherwise be eligible to receive. I will receive a monthly amount of $150.00 (or the bi-weekly equivalent) in lieu of the flexible benefit allowance. ***Employee may still choose premium conversion, vision coverage and the flexible spending accounts.***

By signing this form, I am attesting that I am eligible to participate and that I am either currently covered by a separate group health insurance plan or will be covered by a separate group health insurance plan at or before the beginning of the next plan year and shall provide proof of the separate health insurance plan participation. **If I was NOT in Opt-Out in the previous Plan Year** and the documentation is not provided before the beginning of the new Plan Year, I understand that I will be enrolled in the previous Plan Year's election excluding the FSA's.

Employees that are opting out who have retired from military service and have federal TRICARE insurance benefits are required to provide a copy (both sides) of your DD Form 2 (Retired).

I understand that in order to continue my election of the benefits stated above for subsequent Plan Years, I must reapply for the Opt-Out provision each year. **If I had elected Opt-Out in the previous Plan Year** and fail to sign both the Opt-Out form and "Enrollment Form" and fail to provide the required proof, I will be re-enrolled under the following plans: HealthChoice High Option Medical, HealthChoice Dental, Basic Life Insurance and Disability Insurance.

(Agency name) _____ **(Agency # & Location Code)** _____

(Employee name) _____ **(Employee ID)** _____
(Print Name)

(Employee Signature) _____ **(Date)** _____

(Benefit Coordinator) _____ **(Date)** _____

Revised July 2017