NON AFFILIATED

MEDICAL OPT- OUT FORM

2018-2019 Plan Year

I am declining the health insurance plans offered to me for the plan year 2018-2019. The annual Medical Opt-Out Cash Benefit of $1500 will be added to my paycheck on a bi-weekly basis in the amount of $57.69.

*Name (print)*_____

Date of Hire _____

Signature _____

Date _____

*Cc: Payroll Department*_____