Health Insurance Opt Out Authorization Form
MCEA, MCJEA, MCDAA, MCSSA and ONA represented employees, and unrepresented employee groups

OREGON

Effective Date: _____

Last Name	First Name	Middle Initial
Phone Number	Department	Employee Number

Reason for completing form: ☐ New Hire ☐ Open Enrollment ☐ Eligibility or Status Change

This form along with accompanying proof of other coverage, if applicable, must be received by Marion County Employee Benefits in accordance with newly eligible or open enrollment deadlines, or within 30 days of an eligibility or status change event.

Select One:

☐ **Other Health Insurance Coverage:** I am covered by other insurance and I elect to opt-out of health insurance offered to me by Marion County, and to receive a financial incentive. Proof of other coverage is included with this form. I understand that failure to provide proof of other health insurance within the submission deadline will result in denial of the financial incentive, and I will not be eligible for the incentive until the next Open Enrollment period unless I experience a qualified event or status change as defined in the Plan Rules.

☐ **No Other Health Insurance Coverage:** I am not covered by any other insurance, and I wish to opt-out of the health insurance offered to me by Marion County. I understand that I am not eligible for a financial incentive and I will not be able to enroll in health insurance coverage, or elect to opt out with financial incentive, until the next Open Enrollment period unless I experience a qualified event or status change as defined in the Plan Rules.

☐ **Medicare Eligible:** I am eligible for Medicare coverage and elect to opt-out of health insurance offered to me by Marion County. I understand that I am not eligible for a financial incentive.

Irrevocable Election: I understand I cannot change or revoke this election except during an open enrollment period or if I have a change of status as outlined in the Marion County Benefits Plan Rules. Any election change must be requested within the open enrollment period or within 30 days of the qualifying event.

Employee Signature: _____ EE Number: _____ Date: _____

Return completed form and proof of other coverage to
Marion County Employee Benefits: MCEmployeeBenefits@co.marion.or.us