



OREGON

Health Insurance Opt Out Authorization Form

MCDA, MCEA, MCJEA, ONA, and
Unrepresented Employee Groups

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 Benefit 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 Benefit Plan Rule

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.

Employee
Signature:

EE Number:

Date:

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