



Health Insurance Opt-Out Request Form

I am currently eligible for Health Insurance coverage but I am requesting to utilize the MATC opt out benefit. MATC's plan allows eligible participants, who have other health care coverage, to waive Health Insurance coverage and to instead receive a \$525 yearly cash payment.

****If your other coverage is through an employee of MATC, you are not eligible for the Opt-Out benefit.****

I understand that by signing this form, I will be opting out of the Health Insurance coverage provided by the College.

Cash payments are subject to state and federal tax withholding, as well as FICA and Medicare taxes.

I also understand the **Requirements, Late Enrollment** rules and **Guidelines** as stated below.

Requirements:

- Eligibility Class: Full-time Local 212, Local 587, and Administrative
- Proof of Other Coverage: Documented evidence of other health coverage must be provided to the College (SEE BELOW for proof of other insurance coverage form) along with signed **Health Insurance Opt-Out Request Form**.
- Annual election (during open enrollment period).

Late Enrollment

- Employees have the right to enroll in the health plan at a later date pursuant to HIPAA special enrollment events and timelines and conditions for reentry, subject to the requirements of the plan and related legal authority regarding election changes.

Guidelines

- Employee election is at time of eligibility or annually.
- Information regarding all aspects of the Opt-Out may be obtained from the MATC Human Resources Department.

I have read the above and choose to elect the Opt-Out benefit offered by MATC.

Employee Name (please print)

COSMO ID or SS Number

Employee Signature

Date

Human Resource Representative Signature

Date

****SEE BELOW****

For office use only:

COSMO _____

PAYROLL _____



PROOF OF OTHER INSURANCE COVERAGE
(Must be completed to Opt-Out)

Employee Name: _____

I certify that the above mentioned employee has family medical insurance coverage through

(Name of Employer)

The coverage covers the following individuals:

The effective date of this coverage is/was: _____

Printed Name of Person Completing Form

Signature of Person Completing Form

Title of Person Completing Form

Date

Telephone Number of Person Completing Form