WASHINGTON•SARATOGA
BOCES
BOARD OF COOPERATIVE EDUCATIONAL SERVICES
WARREN•HAMILTON•ESSEX

HUMAN RESOURCE SERVICES
1153 Burgoyne Avenue, Suite 2
Fort Edward, NY 12828-1134

Voluntary OPT-OUT OF HEALTH INSURANCE BENEFITS INTENT FORM for Active SABEA Members 2019 - 2020

The voluntary opt-out of BOCES sponsored health insurance plans is subject to the following conditions. By signing below, I acknowledge my understanding of the requirements to participate.

1. In accordance with the negotiated collective bargaining agreements between the SABEA and the BOCES, a minimum of 85 members must choose to participate in the opt-out of health insurance benefits (medical only) for this benefit to be made available.

2. Any benefit compensation will be pro-rated to adjust for those active members joining or separating from the BOCES after **July 1st** of the fiscal year and for part time unit members.

3. Unit members, who, through qualifying events, require medical insurance after initially opting out, will not be eligible for this compensation.

I hereby declare that it is my intent under Article 12.9, Voluntary Opt-Out of Health Insurance, to opt-out of the BOCES sponsored health plans (medical only) effective **July 1, 2019**, for the 2019-20 year. I understand that I am not committed to participate; it is only an indication of intent. If the minimum threshold of 85 SABEA members is not met, this benefit will not be available to any SABEA members.

BOCES will notify SABEA members by email by **June 21, 2018** as to whether the minimum threshold is met for the 2019- 2020 school year. If so, I understand it will be my responsibility to complete a Health Insurance Declination form and submit it, prior to **June 30, 2019**, along with proof of my other health insurance (the Declination form will be sent with the minimum threshold notice) in order to participate in the opt-out. Additionally, if I desire to enroll in BOCES sponsored medical insurance at some later date, I will have to comply with the applicable requirements of the group policy.

If the minimum threshold of 85 SABEA members is not met to opt-out, I understand it will be my responsibility to notify BOCES by **June 30, 2019** if I choose to enroll or change my health insurance enrollment in any way with the BOCES.

_______________________________ _______________________
Employee's Signature *Date*

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Print Name

Please return the completed form no later than June 15, 2019 to:

Laurie L. Kincaid, Benefits Coordinator
lkincaid@wswheboces.org
Phone 518-746-3303 or 518-581-3303
Fax 518-746-3301 or 518-581-3301

Inter office: Burgoyne Avenue