# Opt Out Form
## Employee Health Insurance Plan
### Linn-Benton Community College

In accordance with the participation requirements for OEBB opt-out provisions, OAR 111-040-0050 and Linn-Benton Community College association agreements, members who elect not to participate in the OEBB Health Plan including medical, pharmacy, dental and vision coverage will be entitled to receive a monthly financial incentive.

**Member Name: ____________________________________________Employee ID# __________________**
**Employee Group: ❑CC ❑EC ❑FC ❑MC**

**I fully understand and certify the following:**

1. To be eligible to opt out of the OEBB-sponsored Health Insurance Plan I must maintain coverage under another comprehensive employer-sponsored group medical benefit plan.
2. The election to opt out of the Health Insurance Plan is entirely voluntary. Linn-Benton Community College is not responsible for any expenses incurred after my insurance termination date for my dependents or myself. Furthermore, my covered dependents and I are not eligible for COBRA continuation coverage.
3. Elections to opt out of the health benefit plans must be made at the time of hire, when initially meeting eligibility or during the annual open enrollment period.
4. If I elect to opt out, I am entitled to receive a monthly amount equal to 30% of the individual premium that would otherwise have been paid to the insurance carrier.
5. Classified employees who work .50 FTE or less may opt out of insurance coverage under the terms stated above without certifying alternate coverage; however, the employee shall be entitled to only 30% of the College's premium obligation for that employee (i.e. 30% of the College's obligation to pay 50% of the cost of employee-only coverage) per Article 30 of the Classified Association Agreement.
6. If I elect to opt out of the Health plan, I will continue to be enrolled in the college-paid basic life and dependent life plan. I understand I am eligible to participate in the supplemental life insurance plan, which includes employee and dependent coverage options.
7. If I elect to opt out of the medical benefit plans, I may enroll in the dental and vision benefit plans.
8. If, at a later date, I wish to re-enroll as a member of the College's health plans, I understand I will no longer be eligible for the monthly financial incentive. I also understand I may enroll in the college's benefit plans during the next open enrollment unless current coverage ends prior to that event.
9. Coverage for previously OEBB-eligible employees or a previously OEBB-eligible dependent enrolling in the dental and/or vision plans during an open enrollment period will be limited to routine and preventive care for the first 12 months.
10. Eligible employees who enroll in the dental or vision plans, or who add previously OEBB-eligible dependents to the dental and vision plans due to a loss of other coverage, will not be subject to waiting periods.
11. I agree to return to LBCC all payments made in error or for fraudulent acts which include, but are not limited to, the following: (a) failure to report change and/or Qualifying Changes in Status timely; (b) falsifying information in order to receive opt out Incentive payments.
12. I understand that if I become ineligible for the financial incentive due to the loss of other coverage, I must re-enroll in the OEBB Health Plan within 30 days of loss of coverage or wait until the next open enrollment period.

- **I certify I am covered under another comprehensive employer-sponsored group medical benefit plan and I wish to opt out from the following OEBB Health Plans: ❑ Medical ❑ Dental ❑ Vision**

- **I am a classified employee (.5 FTE load or less) and wish to opt out from ❑ Medical ❑ Dental ❑ Vision**

**Member Signature: ____________________________________________Date: ______/______/_________**

**To opt out send completed form to Human Resources, LBCC, 6500 Pacific Blvd. SW, Albany, OR 97321. 541-917-4424. Also, logon to the OEBB on-line benefits system and indicate your election to opt out.**

| HR Use Only | Monthly Opt Out Incentive Amount: $_____________<br>Effective: _____/_____/_____ | |
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