LEBANON SCHOOL DISTRICT

OPT OUT BONUS

When opting out of the Lebanon School District Capital Blue Cross Plan, please note that you are Opting Out for the **entire calendar year.** If you have a valid "Life Status Change" and need to take advantage of our health insurance plan during that calendar year, you will need to reimburse the Lebanon School District the entire Opt Out Bonus amount paid to you for the calendar year in which you enroll in our health insurance.

I understand the Lebanon School District will make payroll deductions for any Opt Out bonus paid to me during a calendar year in which the bonus is forfeited due to a Life Status Change requiring my participation in the district health insurance coverage.

Employee Signature Position Date

Capital BlueCross
An Independent Licensee of the Blue Cross and Blue Shield Association

P.O. Box 773132
Harrisburg, PA 17177-3132

WAIVER OF GROUP HEALTH INSURANCE COVERAGE

Health care benefit programs issued or administered by Capital BlueCross and/or its subsidiaries, Capital Advantage Insurance Company® and Keystone Health Plan® Central. Independent licensees of the Blue Cross and Blue Shield Association. Communications issued by Capital BlueCross in its capacity as administrator of programs and provider relations for all companies.

ALL SHADED AREAS MUST BE COMPLETED

1. APPLICANT INFORMATION

APPLICANT'S NAME	(LAST)	(FIRST)	(MI)	SOCIAL SECURITY NO.
SPOUSE'S NAME	(LAST)	(FIRST)	(MI)	SOCIAL SECURITY NO.

2. VALIDATION STATEMENT

I hereby certify that I have been given the opportunity to participate in the group health insurance plan provided by my employer through Capital BlueCross and have been informed of the consequences of not enrolling in such plan at this time. I understand that if I reject the group health plan on behalf of myself and/or my spouse or other eligible dependents, the group health plan will not provide any benefits on behalf of those individuals for whom I have waived coverage With this knowledge, decline to enroll:

☐ MYSELF ☐ MY SPOUSE ☐ MY ELIGIBLE DEPENDENTS

3. OTHER INSURANCE INFORMATION

Complete the following information for applicant and/or spouse and/or other eligible dependent(s) waiving coverage because they are currently covered for health care services with another health care plan. A copy of the current health insurance ID card is required for all employees waiving coverage or enrolled/enrolling on their spouse's health coverage for any group having 50 or fewer contracts.

NAME OF CONTRACT HOLDER	NAME AND LOCATION (STATE) OF HEALTH CARE PLAN/INSURANCE CO.	POLICY/IDENTIFICATION NO.	PLEASE INDICATE THE TYPE OF COVERAGE WITH OTHER CARRIER.			
			MEDICAL	DRUG	DENTAL	VISION

4. WAIVER INFORMATION

NAME (LAST) (FIRST) (MI)	RELATIONSHIP TO EMPLOYEE	SOCIAL SECURITY NO.
a. APPLICANT		
b. SPOUSE		
c ELIGIBLE DEPENDENT		
d ELIGIBLE DEPENDENT		
e ELIGIBLE DEPENDENT		
f. ELIGIBLE DEPENDENT		

5. STATEMENT AUTHORIZATION I understand that in the event that I decide to apply for this coverage at a later date, I and/or my spouse and/or any other eligible dependents, may be subject to certain policy limitations.

EMPLOYEE SIGNATURE	DATE
NAME OF GROUP	GROUP NO

C-69 (4/2011)

DID YOU INCLUDE COPIES OF YOUR ID CARD?