

ALPINE UNION SCHOOL DISTRICT

Insurance Buy-Out Option (2024)

Certification of Insurance Coverage

I, _____, understand that if I have medical benefits through another source, I can take the option of the \$1,000 cash payment (\$100 per month, September - June). I understand it is my responsibility to investigate the current plan offered outside the District to make sure that I am covered under all circumstances.

I certify that I will be covered under the _____ (health plan) sponsored by _____ (company), through my spouse's employer, and that I will notify the Alpine Union School District if my coverage should be cancelled at any time during 2024 (see Notice of Special Enrollment Rights below).

It is expressly understood and agreed that the District, its officers, agents and employees, have made no representation regarding, and are not responsible for, any choice made by me or other consequences of the group of employees, and I understand that I may not make changes until the next open enrollment in October, 2024.

Signature

Date

**** NOTICE OF SPECIAL ENROLLMENT RIGHTS ****

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends.

All employees participating in the Insurance Buy-Out Option must return this completed form to the Benefits Department each year at Open Enrollment and attach evidence of other coverage.