

**Putnam County School Consortium****EMPLOYEE BENEFITS  
2024 DENTAL OPT-OUT ATTESTATION FORM****EMPLOYEE INFORMATION**

|   |   |                        |                           |
|---|---|------------------------|---------------------------|
| Name  |   | Social Security Number |                           |
| Street Address  |   | City                   | State Zip                 |
| Date of Birth<br>____/____/____   | Telephone Numbers<br>Home (    )                      Work (    )                             |                        | Employer Name and Address |
| Marital Status<br><input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed | <input type="checkbox"/> Divorced <input type="checkbox"/> Separated      Marital Status Date |                        |                           |

**PUTNAM COUNTY SCHOOL CONSORTIUM HEALTH BENEFITS OPT-OUT ELECTION***Complete this section if you are eligible for the Opt-Out Program*

Employees must attest below that they are covered under other employer-sponsored group health insurance coverage as of the opt-out effective date, to be eligible for the Opt-Out Program. **Forms can be faxed to (419)-596-3861 or mailed to Treasurers office: 5211 SR 634 Continental, OH 45831**

**Check one:**

- ☐ I am electing to opt out of Individual coverage in exchange for a \$100 annual taxable amount.
- ☐ I am electing to opt out of Family coverage in exchange for a \$250 annual taxable amount (dependent information must be provided when electing Family opt-out).

**Other employer-sponsored group health insurance information (must be provided)**

Name of Covered Employee: \_\_\_\_\_ Covered Employee's Date of Birth : \_\_\_\_\_

Covered Employee's SSN: \_\_\_\_\_ Name of Covered Employee's Employer : \_\_\_\_\_

Effective Date of Alternate Health Insurance Coverage : \_\_\_\_\_

Name and Address of Alternate Health Insurance Coverage : \_\_\_\_\_

**ATTESTATION***All employees complete this section*

I have read the Opt-Out Program materials and instructions and I attest to the following:

- I am covered under another employer-sponsored group health plan that is in effect as of the opt-out effective date and have provided my alternate plan information.
- I understand that I must promptly report changes to information I have provided above which may impact my eligibility.
- I understand that I may choose to opt out of Family coverage *only* if I have Putnam County School Consortium eligible dependents.
- I understand that this election is for 2024 only.
- I meet the qualifications to elect the Health Insurance Opt-out Program.

Employee's Signature **(Required)** \_\_\_\_\_Signature Date **(Required)** \_\_\_\_\_