Putnam County School Consortium	EMPLOYEE BENEFITS 2024 MEDICAL OPT-OUT ATTESTATION FORM

EMPLOYEE INFORMATION

Name			Social Security Number
Street Address	City	State	Zip
Date of Birth _____/_____/_____	Telephone Numbers Home ( ) Work ( )		Employer Name and Address
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ 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 $1,200 annual taxable amount.

☐ I am electing to opt out of Family coverage in exchange for a $3,250 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)**_____