ENLOE HEALTH

OPT OUT CREDIT - ENROLLMENT FORM

PLAN YEAR: JAN 1 TO DEC 31, **2026**

SECTION 125 PLAN

Effective date: _____

Office Use Only

To start your credit, submit this form during open enrollment (Oct. 15th thru Nov. 15th) or within 30 days of a status change or qualifying event.

EMPLOYEE NAME: _____ *EMPLOYEE I.D. #.* _____
Located on your employee ID card

DEPARTMENT: _____

CHOICE ONE: CORE MEDICAL & DENTAL BENEFITS

If you are paying medical or dental insurance premiums, for either yourself or your dependents, under choice one, the premiums will automatically be deducted on a pre-tax basis. It is not necessary to sign this form for this particular benefit.

OR

☐ **CHOICE TWO: "OPT OUT"** OF MEDICAL AND/OR DENTAL PLAN

A SPENDING CREDIT IS AVAILABLE for employees who meet these criteria:

- ☑ Are a full time status benefit-eligible employee (72 to 80 hrs. per pay period)
- ☑ Completed the on-line enrollment declining the benefit(s)
- ☑ Have another employer's group coverage benefit plan. **(This cannot be MediCare, Medi-Cal, coverage purchased on the individual market, including through Covered California, or an Enloe plan through a spouse or a parent.)**

THE MONTHLY "*OPT OUT*" CREDIT IS:	**$50.00 - GROUP HEALTH** **$ 7.00 - GROUP DENTAL**
☐ I certify I and all of my eligible tax dependents, including my spouse, have other **EMPLOYER GROUP HEALTH COVERAGE**: Name of family member through whom coverage is provided: _____ Name of Employer: _____ Name of Health Insurance Carrier: _____	☐ I certify I and all of my eligible tax dependents, including my spouse, have other **EMPLOYER GROUP DENTAL COVERAGE**: Name of family member through whom coverage is provided: _____ Name of Employer: _____ Name of Dental Insurance Carrier: _____

AMOUNT, IF ANY, ADDED TO MY PAYCHECK FROM **CHOICE TWO** (OPT OUT Credit) **$_____ per month**

This amount will be added to your paycheck on the first pay period of each month.

- ☑ I declare under penalty of perjury the information on this waiver is correctly recorded, complete and true. I understand if I lose other group coverage, I will no longer be eligible for the Opt Out Credit and must report the information to the Enloe Medical Center Human Resources department.
- ☑ I understand I may enroll in medical and/or dental benefits at Enloe within 30 days of a loss of other coverage, a qualifying event, or a special enrollment right (see Enloe Medical Center Employee Medical and Dental Benefit Plan document).
- ☑ I understand other **EMPLOYER GROUP HEALTH COVERAGE** does not include coverage purchased on the individual market, including through Covered California, MediCare, Medi-Cal or coverage through another Enloe employee.
- ☑ **I understand I must complete the Opt Out Credit form during annual open enrollment period each year to continue to receive this credit. My election to receive the Opt Out Credit is for the current plan year only and will not renew automatically for future plan years.**

I hereby elect to participate in the above referenced Sec. 125 Cafeteria Plan. I have or will receive the Summary Plan Description and the plan information summary; to be given to me by my employer.

If I am a full-time employee and I *opt out*, I agree that any monies received will be paid to me monthly as taxable income.

- I understand that elections for insurance coverage and Opt Out Credit, may only be changed at plan-year end (or midyear if due to special HIPAA enrollment rights or a change in my employment status resulting in benefit eligibility).
- I understand that the Cafeteria Plan Elections are for the entire plan year and may only be changed during the plan year due to an approved status change as described in the Section 125 Summary Plan Description.

EMPLOYEE SIGNATURE: _____ **DATE:** _____