OPT-OUT INCENTIVE ELECTION FORM

If you are covered under another Health and/or Dental plan and will not be enrolled in a DRBA Health and/or Dental plan, as either an employee or covered dependent, you are eligible to participate in the Opt-Out Incentive Program. If you wish to participate, please complete this form, and return it to the HR-Benefits Office for processing prior to the first pay of the new plan year.

A new form is required annually prior to the start of each new plan year.

I. EMPLOYEE INFORMATION

EMPLOYEE ID #: ____
EMPLOYEE NAME: ____
STREET ADDRESS: ____
CITY/STATE/ZIP CODE: ____

II. OTHER HEALTH COVERAGE INFORMATION

NAME OF OTHER PLAN SUBSCRIBER (spouse?): ______________________________________
NAME OF OTHER PLAN SPONSOR (spouse's employer?): _______________________________
NAME OF OTHER HEALTH PLAN PROVIDER (insurance company?): ________________________
OTHER HEALTH PLAN IDENTIFICATION/MEMBER NUMBER: _____________________________

(You MUST attach copy of your ID card from the OTHER HEALTH Plan to this form.)

III. ELECTION TERMS and CONDITIONS (Please select the waived coverage.)

A) I am eligible for ***Employee Only coverage*** and choose to opt out of the following DRBA plans:

Health Plan ($1,300 Annually)	Yes	Dental Plan ($130 Annually)	Yes

B) I am eligible for ***Employee & Spouse coverage*** and choose to opt out of the following DRBA plans:

Health Plan ($2,600 Annually)	Yes	Dental Plan ($130 Annually)	Yes

C) I am eligible for ***Employee & Child(ren) coverage*** and choose to opt out of the following DRBA plans:

Health Plan ($2,080 Annually)	Yes	Dental Plan ($130 Annually)	Yes

D) I am eligible for ***Family coverage*** and choose to opt out of the following DRBA plans:

Health Plan ($3,120 Annually)	Yes	Dental Plan ($130 Annually)	Yes

- **I hereby elect to participate in the DRBA Opt-Out Incentive Program for the _______ Plan Year.**
- **I agree to furnish proof satisfactory to the DRBA of my other existing health coverage for me and my eligible dependents to qualify for the Opt-Out Incentive.**
- **I understand that I cannot change this election during the Plan Year unless I experience a Qualifying Life Event (QLE).**

____ ____________________

(Employee Signature) **(Date)**

You can either digitally sign this form by following the prompts online or you can print this page. In either case, the form must be signed and dated and submitted to the Benefits Office via inter-office mail or emailed to payroll.benefitsadmin@drba.net, as soon as possible.

____ ____________________

(Benefits Administrator Sign-Off) **(Date)**