Attachment 4

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CSWD REQUEST FOR THE OPT-OUT OPTION

TO THE HEALTH INSURANCE PLAN – Effective January 2022

I hereby request the Opt-Out option to CSWD's Health Insurance Plan. I understand that by choosing this option, I (and/or my dependents) will have **NO HEALTH CARE COVERAGE PROVIDED BY THE CSWD.** I further understand that in lieu of the Health Insurance Plan, I will receive a cash payment for the plan, which I am eligible:

a) Single coverage - $178.00 per month
b) 2-person plan - $355.00 per month
c) family plan - $496.00 per month

This amount is subject to change annually, mid-year with the budget, or upon change of coverage. Attached is a copy of my insurance card to serve as proof of my coverage on another Health Care Plan. I understand that health care coverage varies among providers and the Plan that I am covered on, under another's policy, may not cover my (and/or my dependents') claims. I have taken this into consideration prior to my decision to request the Opt-Out option and knowingly assume the risk that I may be putting myself in a situation of having inadequate coverage. I agree to notify the Administrative Manager Amy Jewell in writing of any change in coverage, which would differ from the information shown on the attached insurance card.

I further agree, that having voluntarily chosen the Opt-Out option that I will hold CSWD harmless of any medical bills, loss of payment or hardship that I (and/or my dependents) may incur due to inadequate health care coverage. I agree that it is my responsibility to read and understand the terms and conditions listed in the Health Plan that I am covered on, under another's policy, and that I will be personally responsible for the consequences caused by lack of interpretation and/or understanding on my part.

_______________________________________ _______________________

Employee Signature Date

Authorization for the Opt-Out Option to Health Insurance

I have reviewed the attached proof of insurance and hereby authorize this request for the Opt-Out option to the CSWD's Health Insurance Plan.

______________________________________ __________________________

CSWD Director of Administration Date

(employer to attach copy of employee's insurance card to this authorization)