Pajaro Valley Unified School District

Benefits Department
294 Green Valley Road
831 786-2317, fax 831 728-6996
mark_bernhardt@pvusd.net
kristina_carrillo@pvusd.net

Request to Opt-out of Health & Welfare Plan

Date: ____________________________________

Name: ____________________________________

Address: ____________________________________

____

Send this completed form to the Benefits Department. This form may be faxed, but the original must be sent to our department also. Your payroll deduction will not terminate until we have received this form. You can only Opt Out if you are working less than 90%. Please initial ALL benefits being declined.

___Medical, Dental and Vision

By my signature below, I attest to the fact that I have coverage independently of Pajaro Valley Unified School District (and must provide proof of that coverage to the Benefits Department) and I understand that by opting out of the PVUSD health and welfare plan that I may not re-enroll unless a qualifying event occurs of the following nature:

- Loss of insurance coverage
- Change in the employment status of the employee or spouse, such as the termination or commencement of employment which affects loss of medical coverage
- Open Enrollment Period each MAY for coverage to commence October 1st
- Loss of coverage due to divorce/death

I understand that I must notify the Benefits Department within 30 days of the loss of my coverage, should a qualifying event occur, to obtain the necessary paperwork to enroll in the health insurance plan. Failure to do so will result in denial of coverage for family members and myself.

____________________________________	____________________________
(Signature)	(Work Location)
____________________________________	
(Social Security Number)	
____________________________________	____________________________
(Print Name)	(Phone Number)