Insurance Opt-Out Election Form – Pensioner

Name:	**Date of Birth**:	**EE ID #**:	
Address:	**City**:	**State**:	**Zip**:

Instructions: Mark the coverage(s) you are opting out of and whether or not you are opting out permanently or you wish to preserve your right to opt back into Metro's plans at a later date. Your coverage will end the first of the month following this 30-day notice to Human Resources.

☐ Medical ☐ Dental ☐ Vision

☐ **Option 1 for Service & Survivor Pensioners ONLY: I am PERMANENTLY OPTING OUT of Metro's coverage**

I have received a copy of Metro's Policy on Opting Out of and Into Medical Care Benefits for Pensioners and I am electing to **permanently cancel** my Metro insurance plans as marked above. I understand if I do not provide proof of other non-Medicare coverage at this time I may **NEVER** re-enroll in Metro's insurance benefits. I further understand that by electing to cancel my Metro insurance, my spouse/domestic partner (if applicable, he/she must also sign below) will NOT be eligible for Metro's insurance plans at the time of my death.

☐ **Option 2: I want to PRESERVE MY RIGHT TO OPT BACK INTO Metro's coverage**

I have received a copy of Metro's Policy on Opting Out of and Into Medical Care Benefits for Pensioners and I am electing to opt out of Metro's coverage but want to preserve my right, and the right of my eligible dependents to opt back into the plans in the future. I am providing proof of other non-Medicare coverage for myself and each eligible dependent (if applicable) in accordance with the Policy guidelines. I further understand if I or my dependents lose the other non-Medicare coverage or have an eligible change in status, we may re-enter Metro's insurance plan by providing proof to Human Resources of the loss of coverage within 60 days of the eligible change in status. If I fail to reenter the plan within 60 days of the event, I understand I cannot re-enroll in Metro's coverage at any point in the future.

My other coverage ☐ **was** ☐ **was not** obtained through the Affordable Care Act's Marketplace Exchange.

_____ Date:_____

Pensioner's Signature

SPOUSE/DOMESTIC PARTNER ACKNOWLEDGEMENT: As the pensioner's spouse/domestic partner, I understand that I will no longer be covered as a dependent under the plan(s) marked above. I further understand that if I become eligible for a survivor pension, I will only be able to opt back into Metro's coverage if my spouse/domestic partner and I provided proof of our other non-Medicare coverage in accordance with the Policy guidelines at the time we initially opted out of coverage.

_____ Date:_____

Spouse/Domestic Partner Signature

_____ My Commission Expires:_____

Notary Public or Human Resources Rep

Human Resources Use Only:

Copies of proof of other non-Medicare coverage have been provided for:

☐ Pensioner ☐ Spouse/Domestic Partner

☐ Other dependents:_____

Coverage Termination Date: _____

HR Rep Signature:_____

HR Management Signature:_____