



Employee Benefits  
200 Old Farmingdale Road  
West Babylon, NY 11704  
(631) 376-7703

## WEST BABYLON UFSD HEALTH INSURANCE SECURITY OPT-OUT FORM 2018

Each year we are required to have a signed opt-out form for every employee who opts out of the health insurance program.

Please read, sign, date, and **return this annual form to the Benefits Office at the Business Office** for the **2018** Calendar Year. This form will cover the period of January 1, 2018 through December 31, 2018 only.

1. It is my decision **NOT** to be covered under the Health Insurance Programs offered by the West Babylon UFSD.
2. I am attaching a copy of my health insurance agreement or card as proof that I have comparable or superior health insurance coverage in effect.
3. I understand that this agreement/form will stay in effect for the current program year only.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Employee Name (please print)

**Please check marital status/date:**

Single \_\_\_\_\_ Married/Date \_\_\_\_\_  
Divorced/Date \_\_\_\_\_ Widowed/Date \_\_\_\_\_

**Please list insured holders name and date of birth, along with all dependents names, date of births, and social security numbers covered under this insurance:**

**Insured Holder Name** \_\_\_\_\_ **DOB** \_\_\_\_\_

Name _____	DOB _____	Social Security # _____
Name _____	DOB _____	Social Security # _____
Name _____	DOB _____	Social Security # _____
Name _____	DOB _____	Social Security # _____
Name _____	DOB _____	Social Security # _____

If you have any questions, please call the Benefits office at (631) 376-7703/7704.