MULTNOMAH COUNTY
OPT-OUT AFFIDAVIT -- REQUIRED ANNUALLY

Employee Name: _____ Employee ID #: _____
(please print your full legal name) *(if assigned)*

I certify that my dependents and I (my tax family), for whom I am waiving coverage, are enrolled in other group health coverage that is deemed to be minimum essential coverage. I attest that my tax family and I are not enrolled in an individual plan, or are enrolled in a medical plan offered under a federal marketplace or a state exchange. If required, I agree to provide proof of other medical coverage that is minimum essential coverage.

I understand that by signing this form, I am waiving coverage for myself and my eligible dependents, and that I will not be eligible to enroll in the benefit program provided by Multnomah County until the next open enrollment period, or unless I experience a qualifying Family Status Change.

INDICATE TYPE OF COVERAGE:

I am enrolled in:

☐ Multnomah County Employee or Retiree medical insurance as a dependent of a current County employee or retiree.
Provide Name of Employee/Retiree: _____

☐ an employer-sponsored or union-sponsored group medical plan (provided by your spouse/domestic partner's employer, parents' employer, your second employment, etc). This plan meets the minimum value requirements set forth under the Affordable Care Act (ACA)*. ☐ Yes ☐ No

**Please contact your health plan for assistance in answering this question or consult your plans' Summary of Benefits and Coverage (SBC).*

☐ any other medical plan not listed above. Indicate **type** of medical plan:_____
This plan is: ☐ Individual health plan (plans include but not limited to: Medicare, Medicaid, OHP, individual coverage through Marketplace, etc.) - **STOP: This will not qualify for Opt Out Incentive!** Please choose one of the Multnomah County offered health plans.

☐ Group health plan. This plan meets the minimum value requirements set forth under the Affordable Care Act (ACA)*. ☐ Yes ☐ No

**Please contact your health plan for assistance in answering this question or consult your plans' Summary of Benefits and Coverage (SBC).*

An employee, who has chosen to opt-out and subsequently experiences a qualifying event during the plan year, can make a new health plan election. The employee must complete a Benefit Change Form and provide documentation of the coverage loss. The completed change form and documentation must be submitted to the Employee Benefits Office within 90 calendar days of the qualifying event. The coverage change requested must be consistent with the qualifying event.

The election to opt-out will be considered effective the first day of the month after receipt of the employee's Benefit Enrollment Form and Opt Out Affidavit. Opt-out incentive is not issued during any period when an employee is in an unpaid status. If a retroactive change from opt-out to a medical plan is required, the employee must repay the County for any opt-out incentive already paid for the same period. Employees who opt-out of the medical/vision plan may still elect dental coverage.

NOTICE: Signing this affidavit may or may not have legal implications beyond opting out of County medical insurance coverage for which it is intended. If you desire further information concerning the possible legal consequences of signing this form, please consult an attorney.

I understand that I can use Opt Out incentive for any purpose, but these monies are not intended to reimburse me for an individual plan in the Marketplace or a state exchange plan.

I attest that the certification I have provided herein is true and correct to the best of my knowledge.

Employee Signature: _____ **Date:** _____

Return completed form to: 503/4/Benefits or employee.benefits@multco.us

Updated 09/2016