

LABRAE LOCAL SCHOOLS | INSURANCE OPTIONS

Choose (✓) your bargaining unit:

☐ Certified

☐ Classified

Please make a total of three selections below: one for Medical/Rx, one for Vision, and one for Dental

INSURANCE OPT OUT

In accordance with my Union's Negotiated Agreement, I am waiving insurance benefits for the 2025-2026 school year and request incentive payment for the following eligible coverage.

Please choose (✓) the applicable insurance plan(s) that you are **OPTING OUT** of.

Mark only the proper coverage for which you are eligible.

	Single	Employee/Spouse	Employee/Child	Family
Medical/Rx				
Vision		If you qualify as Employee/Spouse or Employee/Child, you will choose Family for Vision and Dental		
Dental				

INSURANCE COVERAGE

I wish to enroll or keep my current insurance coverage for the 2025-2026 school year and refuse the incentive payment for non-use of insurance.

Please choose (✓) the applicable insurance plan(s) that you are **OPTING IN** for.

Mark only the proper coverage for which you are eligible.

A COB needs completed if choosing Employee/Spouse, Employee/Child or Family for Medical/Rx

	Single	Employee/Spouse	Employee/Child	Family
Medical/Rx				
Vision		If you qualify as Employee/Spouse or Employee/Child, you will choose Family for Vision and Dental		
Dental				

☐ I have made a total of three selections above and I understand this form will be returned if marked otherwise.

PRINT EMPLOYEE NAME

SIGN EMPLOYEE NAME

DATE

Please contact Jessica Cowger at extension 6025 if you...

- Are newly opting out of insurance
- Need to sign up for insurance
- Or have a change in your spouse/dependent(s) employment or insurance benefits

Once completed, please return to the Treasurer's Office through interoffice mail immediately.