CITY OF FORT BRAGG
416 N. FRANKLIN, FORT BRAGG, CA 95437
PHONE 707/961-2823 FAX 707/961-2802

TO: City Manager

FROM: Human Resources

SUBJECT: **Request to Opt Out of the City Health Insurance Plan(s)**

Pursuant to the MOU's and compensation and benefits resolutions currently in effect, I do not wish to participate in the City's health plan(s). I understand that I will receive a $200 per pay period allowance in lieu of the City's health premium contribution.

I am requesting to opt out of the City's health plan(s) as follows (please check all that apply):

_____ Opt out of the REMIF Anthem Blue Cross Medical Insurance Plan (See note below)

_____ Opt out of the REMIF Delta Dental Insurance Plan

I have initialed below to indicate my understanding of the following:

_____ As required, I have attached proof of other medical coverage.

_____ I understand I will automatically be enrolled in the medical plan or employee's coverage will not be terminated until proof of medical coverage is provided to the Human Resources Office.

_____ I wish to opt out of the medical plan but enroll/continue in the dental plan; the dental premiums will be deducted from the $200 per pay period allowance paid to me in lieu of the City's medical premium contribution.

___________________________________ Date:____________________
Employee Signature

____
Print Name Here

APPROVED:

___________________________________ Date:____________________
City Manager (or Designee)

NOTE: Once approved Human Resources will provide a copy to Payroll for processing.

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