**OPT OUT INSURANCE OPTION**

**Wayne County Health Benefit Plan**

**2023-2024 Fiscal Year**

**Please check box and complete the information below, acknowledging your choice to Opt Out of the County’s Healthplan being offered for the 2023-2024 Fiscal Year.**

* I wish to participate in the Opt Out Program. I understand that by doing so I will not be participating in the health care plan provided by Wayne County.

I also understand that I will not be able to change this election until Annual Enrollment unless I have a Qualifying Life Event as defined by the IRS.

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 LEGIBLY PRINT FULL NAME SIGNATURE

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 LAST FOUR DIGITS OF SS N DEPARTMENT

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 DATE H.R. REP