INSURANCE INCENTIVE FORM

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I have been given an opportunity to participate in the County of Elk's Medical Group Insurance Plan and *decline* that coverage for 2024. — **I must provide H.R. with proof of coverage elsewhere by providing a copy of my current insurance card or a letter from the HR Department from the Company I have insurance with otherwise I will not be enrolled in the Insurance incentive program.**

_____ Initial here

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As an incentive, we are offering $150.00 per month to those employees who elect to withdraw from the Health Insurance Program because coverage is held elsewhere. I understand if my spouse loses coverage at his or her place of employment, I will provide proof of this benefit loss, cease receiving $150.00 per month and apply to The County of Elk's Medical Coverage, for coverage to begin the first of the following month. *To enroll in this program, the County of Elk employee must provide proof of coverage elsewhere. This needs to be a letter from spouse's employer identifying County of Elk's employee's name and their effective coverage date on letterhead, or a copy of the insurance card showing proof of coverage.*

I hereby elect to participate in the County of Elk Incentive Plan and withdraw from the County of Elk Health Insurance Program.

_____ _____

Employee's Signature Date

_____ (DECLINING MEDICAL COVERAGE? SIGN UP HERE!)

Employee's Printed Name

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PLEASE NOTE: YOUR INSURANCE INCENTIVE PAY WILL START THE FIRST PAY OF THE MONTH FOLLOWING YOUR FULL 30 DAYS OF EMPLOYMENT. SHOULD YOU HAVE QUESTIONS, PLEASE CALL 814-776-5380.