Healthcare Opt-Out Request

I, _____, wish to opt out of the City of Berkley healthcare plan for the 2026-2027 benefit year. I understand that I am eligible for payment in lieu of healthcare coverage that is payable to me in the next fiscal year as defined by either the appropriate bargaining agreement or the Merit System guidelines. I also understand that, going forward, I must wait for the next open enrollment period if I wish to enroll myself or a family member in the city's healthcare plan, unless I experience a qualified event. I understand that I must provide proof of other coverage in order to receive the opt-out payment.

I wish to opt out of the following insurance coverage (check all that apply):

- ☐ BCBS Medical/Hospital/Prescription
- ☐ ADN Dental
- ☐ ADN Optical

_____ _____

Employee Signature Date

Email the completed form to hr@berkleymi.gov. Please include proof of other insurance coverage when returning this form.