# OPT OUT INSURANCE OPTION
# Wayne County Health Benefit Plan
# 2024-2025 Fiscal Year

**Please check your option and complete the information below, acknowledging your choice to Opt Out of the County's Health Care plan being offered for the 2024-2025 Fiscal Year.** ***Note: Opt Out pay is prorated based on the number of months in the plan year that you are not covered by the County's medical insurance.***

☐ 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 wish to **continue** 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.

| | |
|---|---|
| _____ | _____ |
| LEGIBLY PRINT FULL NAME | SIGNATURE |
| _____ | _____ |
| LAST FOUR DIGITS OF SS N | DEPARTMENT |
| _____ | _____ |
| DATE | H.R. REP |