

## GROUP HEALTH INSURANCE PLAN OPT-OUT NOTIFICATION

I, \_\_\_\_\_, hereby elect **not** to be covered by the Copley-Fairlawn  
PRINT NAME HERE  
City School District's group health plan for the 2022–2023 school year. I have health care coverage under another insurance plan.

I elect to receive a payment of \$750.00 in lieu of health coverage according to the provisions of Article 15.05 OPT-OUT of the CTA Negotiated Agreement. This payment will be included in the first payroll in September 2023.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date