OPTING OUT OF THE DISTRICT MEDICAL PLANS

I acknowledge that the District's health plans available to me have been explained to me by Glendale College, and I know that I have every right to enroll in one of these plans. I now decline to enroll myself, my spouse/domestic partner, and my dependent(s) in any of the District's medical plans. I have made this decision voluntarily, and no one has tried to influence me or put any pressure on me to decline coverage.

I understand that in order for me to decline enrollment in one of the District's medical plans, I must show proof of insurance through my spouse or domestic partner. I acknowledge that, if I and/or my dependent(s) involuntarily lose coverage under my spouse or domestic partner's medical plan, I must request enrollment for myself and my dependents in one of the District's medical plans within 30 days of loss of coverage. The request for re-enrollment must be in writing and proof of termination from the other medical plan must be provided to the District.

If notification to the District is made within 30 days of loss of coverage, re-enrollment in one of the District's medical plans will become effective on the first day of the following month. If I do not notify the District of loss of coverage in my spouse/domestic partner's medical plan within 30 days, I understand I will not be able to re-enroll myself and/or my dependents in one of the District's medical plans until the next open enrollment period. If this occurs, I release the district from any liability for the fact that I will not be able to re-enroll myself and/or dependents until the next open enrollment period. I understand that I will have to exercise my Cobra rights with the other medical plan to maintain my health coverage.

In consideration of waiving my medical coverage in one of the District's medical plans, I will receive a monthly stipend. On the first of each month a census of all employees opting out the GCC medical plans shall be taken. This number will be used to determine the rate of compensation for that month.

I understand that this offer is valid for the opt-out period of January to December 2015. I will receive a stipend check in July 2015 for the period of January to June 2015 and in January 2016 for the period of July to December of 2015.

_____

Printed Name

_____

Signature

_____

Date