Part-time Employee Election/Waiver of Group Insurance Participation

New part-time employees must use this form to either elect to participate in the Group Insurance Program or waive group insurance coverage. ***Failure to complete this form will result in automatic enrollment in the Quality Care Health and Dental Plans with no dependent coverage.*** Part-time employees who change from full-time to part-time status, or current part-time employees whose insurance premiums increase 30% or greater when changing to a lower part-time work percentage, may use this form to waive coverage.

Employee Name: _____ Employee SSN: _____

Premium for Part-time Health and Dental Coverage (premium amount to be completed by agency GIR):

	PT Premium Amount♦		PT Premium Amount♦
HEALTH Coverage	$ /mo.	**DENTAL Coverage**	$ /mo.

Part-time employees who work at least 50% are eligible to participate in the State Employees' Group Insurance Program. Participation in health and dental coverage is voluntary. Basic life coverage is provided at no cost to employees. Vision coverage is provided at no cost to employees participating in the health program.

Before making your decision, you should carefully read the following:

1. If you choose to participate in the health, dental and vision coverage, you will be responsible for the state's portion of the health and dental premiums based on the percentage of time employed. For example, if you work 75% time, the State will pay 75% of the state portion for your basic health and dental coverage. You would be required to pay the remaining 25% of the cost.
2. If you elect **not** to participate in health and dental, you will not be able to enroll in the program until the next Benefit Choice Period (coverage effective July 1 of each year), unless you experience an eligible Qualifying Change in Status.
3. Part-time employees cannot become a dependent of their state-employed spouse.
4. Provisions and conditions of the Group Insurance Program are applicable to you if you elect to participate in the Program.
5. You must make a decision within ten (10) days of your effective date of part-time employment. The effective date of coverage for you and any eligible dependents will be retroactive to your employment date.

Please indicate your choice below and sign.

____ **YES**, I do want to participate in the coverage initialed below and understand I will be responsible for the coverage premiums.

____ Health, Dental, Vision and Basic Life
____ Health, Vision and Basic Life, electing not to participate in Dental. *

*** Only new State employees or employees completing this form during the annual Benefit Choice Period may elect this option. Employees choosing not to participate may only re-enroll in the dental plan during the annual Benefit Choice Period.**

____ **NO,** I do not wish to participate in the State Employees' Group Insurance Program. I understand that I cannot change this election until the next Benefit Choice Period or until I experience a Qualifying Change in Status which would allow me to enroll in the Program.

_____ _____
Signature of Part-time Employee Date

_____ _____
Signature of Group Insurance Representative Date

GIR/P USE ONLY	**Effective Date of Part-time Status:_____ Part-time: _____%** ♦ GIR/Ps should use the Deduction Calculation Screen (5C) to determine the amount of premium due from the member based on the part-time employee's percentage.