2018 Health Insurance Buy Out Program
Enrollment Form

Employee Name	
Address	
Social Security Number	
RFMH Work Location	
RFMH Start Date	
Health Insurance Plan (*at time of cancellation*)	
Individual or Family Coverage?	
Date Coverage Began	
Alternative Health Coverage (**PROOF REQUIRED**)	
Effective Date of Health Insurance Cancellation	_____ / _____/ _____

I have read and understand the Summary of Provisions for the Research Foundation for Mental Hygiene's Health Insurance Buy-Out Program. I understand that if I elect to terminate my participation in the RFMH health insurance program, I may receive a payment as described in the Summary of Provisions, provided I meet all the qualification requirements. I understand that if I decide to rejoin the Health Plan during 2018, I will forfeit, in full, reimbursement for the Buy-Out Program, and I will be subject to the rules and regulations for reinstatement in the health insurance plan and I will not be able to enroll in the pre-tax health program until the next open enrollment period, even if there is a qualifying event.

	/ /20
Employee Signature	***Date***
	/ /20
RFMH Personnel Signature	***Date***

******Please note: Deadline for completed forms is December 21, 2017******