2025 Health Insurance Buy Out Program
Enrollment Form

Employee Name:	
Address:	
Last four of Social Security Number:	
RFMH Work Location:	
RFMH Start Date:	
Health Insurance Plan and Coverage (*at time of cancellation*):	
Individual or Family Coverage (*at time of cancellation*):	
Date First Covered on RFMH Health Plan:	
Alternative Health Coverage for Plan Year 2023:	
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 if I elect to terminate my participation in the RFMH health insurance program, I may receive a payment as outlined in the Summary of Provisions, provided I meet all requirements. If I rejoin the Health Plan at any time during 2023, I will forfeit in full any reimbursement for the Buy-Out Program, and I will be subject to the rules and regulations for reinstatement in the health insurance plan.

Employee Signature	***Date***
Human Resource Certification	***Date***

******Please note: Deadline for completed forms is December 18, 2024******