Health Insurance Buyout Option
Mayfield Central School District
Plan Year: July 1, 2024 – June 30, 2025

Please return to the Business Office Attn: Cassie Kristel

Name: ____ **SS Number (Last 4):** _________________

Address: ________________________________ **City:** __________________ **State:** ____ **Zip:** _______

Date of Birth: ______________________ **Telephone:** ___________________

Email Address: ____

Spouse/Dependent Information Required, if Two-Person or Family Plan:

Spouse Name	Date of Birth	Social Security Number
Dependent Name	Date of Birth	Social Security Number
Dependent Name	Date of Birth	Social Security Number
Dependent Name	Date of Birth	Social Security Number

_____ **I elect *NOT* to participate in the Mayfield Central School District's Health Insurance Coverage as per Article 16.6 (MPSA) Article 12.5 (MTA) or Article 7.4 (MAA)**

PLEASE INDICATE THE ELIGIBLE PLAN WITH A CHECK MARK BELOW

Single plan __________ **Two-Person plan** _____________ **Family plan** __________

Proof of other health insurance, indicating the plan coverage stated above and Group Health Attestation form MUST BE attached to this form. This form will not be accepted without such proof.

I agree to notify the Mayfield Central School District in the event of any changes to this plan.

____

Employee signature **Date**

Office Use
Received _________
Processed_________