Mayfield Central School District
Health Insurance Buyout Option
Plan Year: July 1, 2022 – June 30, 2023

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 15.7 (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, 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**

Reviewed by: _____
Date: _____