

Health Insurance Buyout Option
Mayfield Central School District
Plan Year: July 1, 2023 – June 30, 2024

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
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_____ 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 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 _____