



**Voluntary Reduction in Medical Plan Coverage Form
District Management Employee
January 1, 2010 – June 30, 2010**

Employee Name: _____

Location: _____ Colleague ID: _____

I understand that the following conditions apply to a **Voluntary Reduction in Medical Plan Coverage**:

1. This is a Voluntary Reduction in Medical Plan Coverage to choose an alternate health care plan through Tri-County Schools Insurance Group (TCSIG). There will be a special enrollment period November 2, 2009—November 16, 2009 to implement these changes beginning January 1, 2010, and terminating June 30, 2010.
2. I understand that I will be required to complete a TCSIG enrollment/change form.

If you choose to participate in a **Voluntary Reduction in Medical Plan Coverage**, check the box to the left, and indicate below which level of participation you agree to; and that you have read, understand, and accept the Voluntary Reduction in Medical Plan Coverage conditions described above.

Current TCSIG Plan _____

Agreed to TCSIG Plan _____

Additional conditions:

1. Request to cancel participation will only be granted in cases of a financial hardship and must be approved by the Vice Chancellor Administrative Services.

You may not cancel this agreement. Once this agreement is signed and entered into, it may not be revoked.

Employee Signature: _____ Date: _____

APPROVALS:

Supervisor Signature: _____ Date: _____

CHEX Member Signature: _____ Date: _____

Forward original approved agreement to Human Resources no later than November 16, 2009.

For Human Resources Office Use:

Effective Date: _____ End Date: _____

Personnel Analyst: _____ Date: _____