2025 ACTIVE OPT OUT FORM

Name:_____ **S.S. #**_____

Date of Birth:_____ **Age:** _____

Address:_____ **Town**_____

State:_____ **Zip Code:**_____ **Telephone:** _____

Email Address:_____

1. Who is the primary card holder ☐ Myself ☐ My Spouse ☐ My Parent(s) (The benefits you are utilizing for proof of coverage to enrollment for the Opt-Out Program)
2. Is your Spouse a Camden County Board of Social Services retiree or employee ☐ Yes ☐ No

Eligible Spouse is defined as your spouse under a legally valid **existing** marriage.
Eligible Child/Children are defined as an enrollee's child until age of 26 regardless of the child's marital, student or financial dependency status. Your dependent is not required to be claimed as a dependent on your income tax. Eligibility will continue beyond the limiting age for unmarried children, regardless of age, who are incapable of self-support because of mental or physical incapacitation and who are dependent on you for over half of their support.

	FIRST NAME	LAST NAME	SSN	DATE OF BIRTH	Opt Out Medical and RX Coverage
YOUR NAME					☐
SPOUSE					☐
CHILD					☐
CHILD					☐
CHILD					☐
CHILD					☐

By opting out myself or any of my dependents, I attest that I/we have alternative and comparable Medical, Prescription Drug coverage or both, from another source for the 2025 Plan Year. **Camden County Board of Social Services Benefits Plan rules prohibit the receipt of opt out reimbursement stipend if your coverage is through the SNJHIF**. I understand that if I lose this coverage during the 2025 plan year it is my responsibility to inform the Board within 30 days, so that I, and any eligible dependents, may become covered under the Camden County Board of Social Services Benefits Plan**. I also understand that if my alternative coverage changes to the SHBP it is my responsibility to notify the Board within 30 days**. Further, I understand that I will be required to reimburse the Board for all opt out dollars paid if the Board determines that my dependents were not eligible for coverage or if we did not have alternative and comparable Medical and/or Prescription Drug coverage. It is your responsibility to keep your address and telephone number current with the Camden County Board of Social Services Benefits Division of Insurance.

*****YOU MUST RETURN THIS FORM WITH A COPY OF YOUR ALTERNATIVE COVERAGE ID CARD*****
*****FAILURE TO COMPLETE THIS FORM PROPERLY AND SUBMITTED BY THE DEADLINE WILL RESULT IN TERMINATION OF OPT-OUT*****

Active Signature **Date**

Please mail this form with a copy of your
MEDICAL & PRESCRIPTION alternative coverage ID card
no later than November 22, 2024 to:

Camden County Board of Social Services
Employee Benefits Department
101 Woodcrest Rd Suite
Cherry Hill, NJ 08102

Call 856-225-7753 or email HR_internal@camdenbss.org with any questions