

SCMEBF Opt-Out/Opt-Back-In Form



Name: _____ Member ID (BF#): _____

I would like to:

- Opt-Out** of Benefits
- Opt-Back-In** to Benefits

If you are an Active member, please select the benefits below you would like to Opt-Out/Opt-Back-In to:

ALL Benefits - If you opt-out of all benefits and new benefits are added afterwards you are automatically opted-out of the new benefits unless we are notified.

OR

- Dental – Unlimited General Dentistry, 2 implants per calendar year
- Optical - \$100 per calendar year
- Hearing Aid Reimbursement – up to \$400 every 36 months
- Prescription Co-Pay Reimbursement – up to \$400 per family, up to \$25 per script, \$1 per script after \$400
- Tax Reimbursement – up to \$100 for tax preparation
- Legal (FKM) – Refer to Legal Reference Guide
- Health Insurance Assistance – 15% of the overage paid towards health insurance.
- Specialist Co-Pay Reimbursement – up to \$20 per specialist co-pay, no maximum
- Bereavement (Benefit Fund) - \$25,000 benefit
- Survivor (Benefit Fund) - \$1,000 benefit
- Life Insurance (Lincoln) - \$50,000 benefit
- Disability (Metlife) – Short-term and Long-term
- Identity Theft & Fraud Protection (Aura by Metlife)
- Financial Planning & Credit Card Dispute (JB Greco)
- Behavioral Health (JB Greco)

If you are a Retired member, please select the benefits below you would like to Opt-Out/Opt-In to:

ALL Benefits - If you opt-out of all benefits and new benefits are added afterwards you are automatically opted-out of the new benefits unless we are notified.

OR

- Dental - \$750 family max, \$500 individual per calendar year
- Optical - \$100 per calendar year
- Hearing Aid Reimbursement – up to \$400 every 36 months
- Life Insurance (Lincoln) - \$5,000 benefit
- Identity Theft & Fraud Protection (Aura by Metlife)
- Financial Planning & Credit Card Dispute (JB Greco)

I have chosen to Opt-Out/Opt-Back-In to the benefits selected. I understand I will have to fill out this form again to notify the Benefit Fund of any changes.

Signature

Date

When this form is completed, please email to the eligibility dept at Wendyz@scmebf.org or Doreen@scmebf.org or mail it to the Fund at:

**SCMEBF
30 Orville Dr. Suite D
Bohemia, NY 11716-2513**

Rules

1. You are opted-out/opted-in for benefits as of the date this form is signed.
2. If a member opts-out of all benefits and new benefits are added afterwards you are automatically opted-out of the new benefits unless we are notified.
3. You must fill out this form if you would like to Opt-Back-In to benefits.
4. "Opt-Out" DOES NOT apply to those in the "Self-Pay" Enhanced Retiree Plans. Members in those plans must still fulfill their 2-year minimum enrollment requirement.
5. "Opt-Out" DOES NOT apply to those in COBRA Plans.