SCMEBF Opt-Out/Opt-Back-In Form

Name: _____ Member ID (BF#): _____

I would like to:

☐ **Opt-Out** of Benefits (Please select which benefits below)

☐ **Opt-Back-In** to Benefits (Please select which benefits below)

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 – $4,000 General Dentistry maximum

☐ 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 (Metlife) - $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 (Metlife) - $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 Inquiry@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.