Medical – Opt Out Benefit Form

Instructions: complete the highlighted fillable fields then upload the form in the Attachments section, when completing your enrolment.

Name:_____ Employee ID:_____

Applicable Benefit Year:_____

Alterative Coverage Details

Name of individual whose policy you are covered under: _____

Name of insurance company:_____

Policy number:_____

Effective date of alternate coverage:_____

Acknowledgement

I understand that by opting out of the Capital Power Operations (USA) Inc. Medical Insurance (e.g., medical and prescription drug coverage) that I will not be allowed to update my medical coverage until the next enrollment period or due to qualified life event.

I acknowledge that I will receive an Opt Out Benefit that will be added to my paycheck in equal amounts over the course of the year. The annual Opt Out Benefit amount is listed in the annual enrolment guide. This money will be treated as taxable income and is not eligible for the 401(k) plan contributions or considered as part of my base compensation for bonus determination purposes.

_____ _____

Employee Signature (typed) Date