



Employee Opt-Out Form

Date _____, 200____

I, _____, have chosen not to participate in the CustomCare Tailored Health Care plan that my employer, _____, has enrolled in.

I understand that the CustomCare plan allows participants to be reimbursed for medical and dental expenses up to the maximum spending limit the employer decides to allocate. I also understand that this benefit would be passed on to me tax-free, is entirely employer funded and that there would be no cost to me if I did choose to participate.

Please do not include me in my employers CustomCare plan.

COMPANY NAME _____

PRINTED NAME _____

SIGNATURE _____