OMNIVISION®

MEDICAL COVERAGE OPT-OUT FORM

Plan Year: 2025

WAIVER OF PARTICIPATION

The OMNIVISION Employee Benefit Program has been explained to me and I decline to participate in the medical plan at this time. I understand that as of January 1, 2014, I am required by federal law to maintain an acceptable level of health insurance coverage for myself and my dependents, or be subject to a tax penalty. I understand that if I waive coverage now, I must wait until the next Plan Year/Open Enrollment Period to enroll unless I experience a qualifying life event as defined by OMNIVISION's Plan.

I further understand that this does not affect my continued participation in the Company's 401(k) plan or voluntary programs (as I choose to enroll in) and other benefit plans such as holidays, vacation, life insurance, and worker's compensation program.

OVT Employee Name:	
OVT Employee Signature:	
Date:	

By entering my name, I acknowledge that I read and understood the above regarding waiving my medical coverage.

OPT-OUT ELECTION

I choose to waive participation in the medical coverage offered through the OMNIVISION Employee Benefit Program, and I certify herein that I (and any of my dependents) have medical coverage under another group insurance plan named below. For the declination of medical coverage offered under the OMNIVISION Employee Benefit Program, I elect to receive a cash payment in the form of taxable income under OMNIVISION in the amount of $300 for each month in which my waiver of participation remains in effect.

I understand that the receipt of this opt-out payment amount is conditioned upon my continued coverage under another group medical insurance plan, and that I am responsible for updating OMNIVISION should I at any time cease to remain covered under the group insurance plan named below. I also understand that the voluntary termination of my coverage under another group health plan will not necessarily allow me the opportunity to enroll mid-year in the OMNIVISION Employee Benefit Program unless I experience a qualifying life event as defined by OMNIVISION Plan.

Name of Employer/Organization providing other Group Coverage:	
Insurance Carrier:	
Name of Insurance Holder:	
OVT Employee Name:	
OVT Employee Signature:	
Date:	

By entering my name, I acknowledge that I read and understood the above regarding my Opt-Out election.