OPT-OUT/WAIVER ELECTION AGREEMENT FOR MEDICAL COVERAGE

Must print in Black or Blue ink ONLY

ID #	Last Name, First Name
Department	

MEDICAL OPT-OUT

I elect to opt-out of my sponsored medical coverage. I am *currently enrolled* in another employer's group medical plan as specified below. **ALL FIELDS MUST BE COMPLETED**

Name of Plan		Employer Providing Coverage	
Medical:		Medical:	

Employer Contact to Verify Coverage		Employer Contact Telephone	
Medical:		Medical:	( )

Attach Proof of Coverage		Effective Date of Coverage	
Medical:	Check appropriate box: ☐ Copy of Card ☐ Certificate of Coverage	Medical:	

Note: Read the Opt-Out Agreement on page two of this form, sign and date

WAIVER TO AN EMPLOYEE

I elect to waive my enrollment as a subscriber in the sponsored medical plan because I am covered by another City employee. I will be covered as a dependent as specified below.

Provide the following information for the employee you are waiving to:

ID #	Last Name, First Name	Department

Relationship	Name of Plan	
☐ Spouse ☐ Domestic Partner ☐ Parent	Medical:	

Note: Read the Waiver Agreement on page two of this form, sign and date

Opt-Out Agreement

I understand, accept and agree to the following terms and conditions:

- I understand that I must have comparable, employer-sponsored group medical plan coverage in order to Opt-Out.
- I understand that until I report a change in my other health coverage I will not be enrolled in the employer's medical plan.
- The Employer may verify or request additional information on the plan stated on this form at any time. In the event verification of my stated coverage above indicates that the coverage does not exist or I fail to timely provide the requested information, the employer will revoke my Opt-Out election.
- **I am responsible for notifying the Employer within 30 days of loss or change in the employer's group medical plan as stated on this form. Failure to report the loss or change within 30 days will result in denial of before tax payment of my premiums and denial of dependent coverage.**
- The Employer's acceptance of this Election will be based on timely submission and adequate proof of comparable coverage. My failure to provide written change within 30 days will result in denial of my Opt-Out Election.
- The Employer will determine the effective date of this Opt-Out Election, in accordance with IRS Code Section 125, carrier contracts and the Employer's standard administrative practices.
- I am responsible for all retroactive premiums for coverage that may be required to insure the least amount or no break in medical coverage. If a gap in coverage occurs, I will be personally liable for medical claims and lack of coverage.
- I hereby release and hold harmless the Employer, its officers, agents and employees from any liability arising from the fact that a sponsored medical plan is not provided to me and I hereby waive any rights to be afforded such coverage.
- **I understand that I may not be required to recertify at open enrollment. If not required, the employer will maintain my Opt-Out status until I say otherwise.**

I certify under penalty of perjury that the information contained on this document is true and correct.

Employee Signature	Date

FORM MUST BE COMPLETED, SIGNED AND RETURNED TO HUMAN RESOURCES

Waiver Agreement

I understand, accept and agree to the following terms and conditions:

- I understand that if my spouse, domestic partner, or parent terminates employment, I will be required to enroll in a sponsored medical plan within 30 days of my spouse's, domestic partner's, parent's termination.

I certify under penalty of perjury that the information contained on this document is true and correct.

Employee Signature	Date

FORM MUST BE COMPLETED, SIGNED AND RETURNED TO HUMAN RESOURCES

Office Use Only

Reviewed By (Print & Sign)	Date Received