TOWN OF NEEDHAM
EMPLOYEE HEALTH INSURANCE WAIVER FORM

Please complete the following information. This form must be accompanied by the insurance plan's applicable dis-enrollment form, and a letter serving as proof of enrollment in alternative coverage on either the insurance company's or employer's letterhead, which must be received within 30 days from the effective date of coverage.

Employee Name:		**Department**:	
Present Town-Sponsored Insurance		**Alternative Insurance**	
Plan Name:		Primary Policy Holder:	
		Entity provided by:	
Coverage Type: *Family / Individual*		Insurance Carrier:	
		Plan Number:	
Date of Voluntary Termination:		Coverage Type:	
		Effective Date:	

I, _____, hereby elect an annual monetary allowance of $2,000 for an individual plan / $4,000 for a family plan in lieu of Town-sponsored group health benefits. I understand that this amount will be divided equally among and paid via my normal payroll cycle over the plan year. I also understand that this payment will be less any required withholdings, and will not be added to my base pay, not used in computation or subject to retirement withholdings.

I certify that insurance coverage is in force elsewhere as of the effective date above, for losses in regard to medical conditions for me and my dependents, if any.

I hereby acknowledge that I am only eligible to re-enroll in the Town's health insurance plans during the Annual Open Enrollment Period or for a qualifying event. To reenroll, I must complete the required paperwork during the Open Enrollment period or, for a qualifying event, notify my Human Resources Department and complete the re-enrollment process within thirty (30) days of the date of involuntary loss of coverage.

I understand all the terms of the Opt-out Program as stipulated in Board of Selectmen Policy PERS-003: Contributory Insurance Rules and Regulations.

Employee Signature: _____ **Date**: _____

Internal Use Only

Director of Human Resources/designee signature: _____ Date:_____

- □ Insurance Company Disenrollment Form
- □ Original Enrollment Date: _____
- □ Amount Due for current FY: _____
- □ Payroll frequency: _____
- □ Proof of enrollment in alternative insurance