Village of North Palm Beach

Medical Insurance "Opt Out" Waiver

Employee Name: _____
Last **First** **Middle Initial**

Department/Division: _____

I, the above named, do hereby request to waive my coverage in the Village's medical insurance plan and to receive the "opt out" incentive of $85 per month (paid as $39.23 per biweekly pay cycle) as covered by the Village's "Medical Insurance 'Opt Out' Policy" (#08-003). I understand and agree to abide by the terms of the policy and acknowledge that I may request and will receive a copy of said policy from the Human Resources Dept. at any time.

Under the terms of the policy, I understand that I must provide Human Resources with proof of alternate insurance coverage, which must include a minimum of medical, hospitalization, and prescription drug coverage. I agree to show proof of alternate insurance annually or I will be enrolled in the Village's lowest cost plan for employee coverage (only) and will not receive further opt out monies while on the Village's plan. I understand that this policy shall only apply to the group medical insurance policy and I will not receive any compensation for waiving any other employer-paid insurance benefits.

After reviewing the proof of insurance, the Human Resources Department shall confirm that I am eligible to receive the "opt out" monies and will submit a Personnel Action Form (PAF) to the Finance Department for applicable payment of the "opt out" monies.

I acknowledge that once waived, insurance coverage on the Village's group medical plan can only be reinstated as a result of a "qualifying event" (as defined by the Village's medical plan) or during the Village's annual open enrollment period. Failure on my part to maintain adequate insurance and/or to request reinstatement on the Village's group medical insurance plan once alternate coverage has terminated will be viewed as a violation of this policy.

Name of Insurance Carrier: _____
i.e. Cigna, Blue Cross Blue Shield, Aetna, etc.

Name of Primary Member: _____

Effective Date Coverage Began: _____
When did you become covered on this plan

Type of Proof Provided: _____

By signing I acknowledge that I have read and understand the above information and agree to abide by the Village's "Medical Insurance 'Opt Out' Policy" (#08-003).

_____ _____
Employee Signature Date

_____ _____
HR Signature Date