Opt Out Health Insurance Form

Name: _____

Date: _____

Address: _____

Spouse: _____

Dependents Name and ages: _____

_____

Current Coverage: Single _____; Mem. + One _____; Family _____

I _____ am voluntarily opting out of the City of Meriden's Health Insurance Plan. In exchange I will no longer have to pay the weekly cost share and will receive an incentive (if I qualify) of $500 for single coverage; $1000 for member + one; or $1500 for family coverage. These payments will be made in July of 2018.

I have attached proof of other **non City of Meriden/Board of Education coverage**.

I understand that I may opt back in for July 1st of the following year unless other coverage is terminated due to federally documented death, divorce, or loss of employment. If employees opt back in due to one of the above qualifying events, they must make arrangements with the Personnel Department to pay back a prorated portion of the opt out provision (i.e., $125 per month of opt back for family) prior to being put back on to the City's health insurance. Employees may only return on the first of each month and must have requested to return any paid monies owed at least fifteen (15) calendar days prior to the first of the month.

For this year I may opt out until June 1, 2018.

_____ _____

Signature Date

_____ _____

Human Resources Director Date