2022 Waiver of Medical Insurance

Employee Name: _____
(Last) (First) (MI)

Last 4 Digits of SS #:_____ Department:_____

I acknowledge that I have been offered the opportunity to be covered by a City group medical insurance plan for myself and my eligible dependents. Proof of coverage is required with submission of the waiver. I understand that the City may require proof of coverage from another group medical insurance source at anytime while receiving the City's contribution under the waiver.

I understand that I will not be able to revoke this waiver and elect coverage until the next open enrollment period or unless I experience a qualifying life event. A qualifying life event may include loss of coverage, marriage, divorce, change in employment status, etc. (For more information about qualifying life events, contact the Human Resources Department).

I acknowledge that my dependents and I (for whom I am waiving coverage) are enrolled in other health coverage that is deemed to be minimum essential coverage.

I understand that I must promptly report changes that may impact my eligibility or payment of the City's contribution under the waiver (i.e. loss of other group medical insurance coverage, divorce, death, etc. For more information about eligibility, contact the Human Resources Department). I understand that if I fail to do so, I am responsible for any waiver over payments made to me in error.

I further understand that this election is for only one plan year. I understand that I will have to resubmit a waiver request if I am eligible and choose to continue to waive City group medical insurance for myself and my eligible dependents.

☐ I waive enrollment for my eligible dependents and myself because we have other group medical insurance coverage (proof of coverage is attached).

Insurance Company name: _____ Group No. _____

Through (employer name): _____

Employee Signature: _____ Date: _____

(Human Resources Use Only):

☐ Proof of enrollment received
☐ Waiver is APPROVED
☐ Waiver is DENIED

Health Benefits Officer Signature

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