TOWN OF WESTON
EMPLOYEE HEALTH INSURANCE WAIVER FORM

Please fill in the appropriate blank spaces. This form must be accompanied by a Commonwealth of MA Health Insurance Responsibility Disclosure Form (HIRD) and GIC's Enrollment Form-Mun1 and proof of other insurance coverage. Return all documents to Town HR Dept at Town Hall.

NAME: _____ DEPARTMENT: _____

SOCIAL SECURITY NUMBER: _____

Present Town of Weston Group Coverage Plan Name: _____ Individual ☐ Family ☐

Other Health Insurance Information:
(Please attach verification of other health insurance)

Name of Person Listed on Plan as Primary Insured:
_____

Name of company/entity through which coverage is obtained:
_____

Insurance Carrier: _____

Plan Number: _____ Individual ☐ Family ☐

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I, _____, hereby elect an annual monetary allowance of **$2,750** for an individual plan / **$5,500** for a family plan in lieu of Town-sponsored group health benefits. I understand all the terms of the Opt-out Program as stipulated in the Side Letter of Agreement. I understand that I may not renounce this agreement and re-enroll in a Town-sponsored health insurance plan except:

(A) During the periods of open enrollment I may exercise the option to enroll in an offered health plan and end the allowance without showing proof of loss of alternative coverage.

OR

(B) Upon submission of satisfactory proof of non-voluntary loss of alternative coverage through no fault of my own, I may re-enroll in a Town-sponsored health insurance plan with waiver of waiting periods, to the maximum extent allowed by law.

Signed _____Date _____

Assistant Town Manager Approval_____ Date _____

Date health coverage began with the Town: _____
Breaks in coverage during the last two years: _____
Has employee's share of the premiums been paid: _____

Included with waiver:
HIRD Form ____
Form 1 MUN ____
Proof of other coverage ____
P-2 & P-3 ____