WAIVER OF HEALTH COVERAGE FORM

EMPLOYEE INFORMATION *(Please Print)*

Name:_____ **SS#:** _____

Department:_____ **Home Phone:** _____

Employee Address: _____
Street City State Zip Code

☐ **WAIVER of Health Insurance Coverage** **Effective Date of Waiver:**_____
(beginning of payroll period) *For internal use only*

I understand that by signing and submitting this election form, I acknowledge that I have other health coverage provided in accordance with my collective bargaining agreement or appropriate contract and I am making a binding election to waive the Town of Middletown (the Town) sponsored health coverage for myself and my eligible dependents. This waiver will continue to be effective until such time in the future when/if I choose to elect health insurance coverage, upon eligibility.

I understand that the only time I am able to elect health insurance coverage through the Town is during the annual open enrollment period or if I have a qualifying status change such as permitted and determined by law. I further understand that I must provide proof of such change.

REQUIRED INFORMATION

Identification of my other health coverage *(please attach copy of ID card)*

Name of other employer: _____

Name of other insurance company:_____

Name of Alternate Policy Holder:_____

Plan Name and/or Group Identification No. (from ID card): _____

☐ **RESCIND Waiver** **Effective Date of Coverage Begins**_____
(beginning of payroll period) *For internal use only*

I understand that by signing and submitting this form, I rescind my prior election to waive the Town of Middletown health coverage, as provided under my collective bargaining agreement or appropriate contract. Therefore, if otherwise eligible, I shall now be covered by the Town's health coverage for myself and my eligible dependents.

I acknowledge that I cannot change this election except at open enrollment unless I have a qualifying status change as permitted and determined by law.

Employee Signature:_____ **Date**: _____

OFFICE OF HUMAN RESOURCES ONLY

Accepted by:_____ Date Received: _____