TOWN OF FREETOWN

Health Insurance Waiver Form

I, ____, in consideration for the sum of $1,200, hereby agree to waive my eligibility to obtain health insurance (medical only) from the Town of Freetown.

I further acknowledge that the consideration listed above, less any required withholdings or deductions, shall be paid to me in weekly or bi-weekly installments beginning with the first pay week of the month.

I hereby acknowledge that my decision not to participate in the Town's health plans is made voluntarily, and that I have provided the Town with proof of insurance coverage from another provider.

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

OR

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.

I further acknowledge that I am only eligible to re-enroll in the Town's health insurance plans if one the below listed qualifying events occurs:

1) Marriage or divorce
2) Birth or adoption of a child
3) Death of a family member
4) Lack of coverage through no fault of the employee or subscriber
5) Change in hours, which results in a change of employment status.

To re-enroll I must notify the Town's Benefits Department within 30-days of one of the qualifying events listed above. Upon re-enrollment, the consideration provided for this health insurance waiver program shall be prorated and reduced and all health insurance waiver installment payments shall cease.

I declare I do not have a spouse employed by the Town of Freetown eligible for health insurance from the Town of Freetown.

____
Signature

____
Social Security Number

____
Street Address

____
City, State, Zip

____
Department Head Approval

____
Date

BENEFITS USE ONLY

Waiver Received: Date ____________ Initials____________ Proof of Coverage: Date__________ Initials__________

Health Plan:________________________________ Acceptance Letter Sent: ______________________

12 month Installments - $100.00