TOWN OF UPTON

VOLUNTARY WAIVER OF HEALTH INSURANCE
For Enrollment in Health Insurance Opt-Out Program

In return for the agreement to waive Town health insurance coverage, the Town agrees to pay an eligible employee one of the following amounts:

(1) $1,500.00 for waiving individual health insurance plan coverage

or

(2) $3,000.00 for waiving family health insurance plan coverage

The Town will make the above payment at a rate of $125.00/month (individual plan) or $250.00/month (family plan) on or about the last pay period in each month that the employee deferred coverage from the Town. The opt-out payments will be subject Federal, State, and Medicare taxes.

To be eligible an employee must not have an outstanding court order or agreement requiring the employee to provide health insurance coverage for the employee's spouse, ex-spouse, or dependent children, if any.

To be eligible, an employee must completely remove themselves as either a subscriber or dependent on the Town's health plan. A Town employee is not eligible for the opt-out payment where the employee opts-out of their individual health plan and becomes a dependent on their spouse's plan, when their spouse is also a subscriber on the Town's plan.

To be eligible, an employee must have been a subscriber to the Town's health plan in the immediate twelve (12) month period of the fiscal year prior to agreeing to opt-out of the Town's health plan.

Retirees on the Town's health plan are not eligible for this Opt-Out Program.

If an employee is eligible and elects to opt-out of the Town's health insurance plan, the Town is not responsible for medical coverage effective on July 1, 2015 (except for medical coverage for injuries and illnesses covered by G.L. c. 41, Sec. 111F or G.L. c. 152) and for each fiscal year thereafter that the employee voluntarily agrees to waive health insurance coverage through the Town.

An employee is only eligible to re-enroll in the Town's health insurance plan during the Annual Open Enrollment Period or due to a loss of coverage from the source other than the Town, i.e. a qualifying event under COBRA, such as:

(1) the death of a covered employee;

(2) the termination (other than by reason of the employee's gross misconduct), or reduction of hours, of a covered employee's employment;
(3) the divorce or legal separation of a covered employee from the employee's spouse;
(4) a covered employee becoming entitled to Medicare benefits under Title XVIII of the Social Security Act; or
(5) a dependent child ceasing to be a dependent child of the covered employee under the generally applicable requirements of the plan and a loss of coverage occurs.

To re-enroll, the employee must complete the required paperwork during the Open Enrollment Period or, for a loss of coverage, notify the Town Manager's Office and complete the re-enrollment process within thirty (30) days of the date of loss of coverage.

If an employee does re-enroll in the Town's group health insurance or the employee's employment with the Town ends (termination, resignation, retirement, reduction of hours, layoff, or death) during the fiscal year, the employee will only be eligible for a pro-rated payment.

Each employee agreeing to opt-out of the Town's health insurance plan must acknowledge that they have read and agree to comply with the terms and conditions of the Town's Opt-Out Program on the attached Acknowledgement Form, a copy of which will be placed in the employee's personnel file.

ACKNOWLEDGEMENT

I, _____, hereby acknowledge that I have read and understand the terms of the Town's Health Insurance Opt-Out Program, which I have had the opportunity to ask questions to the Town regarding the Opt-Out Program and inquire of attorneys of my own choosing, and that I am agreeing to waive my right to health insurance coverage through the Town effective July 1, 2015. I understand that I will only be allowed to re-enroll in the Town's health insurance plan during the Annual Open Enrollment Period or if a qualifying event occurs. I also attest to the fact that will be receiving health insurance coverage from another health insurance provider.

_____ _____

Employee Name Date

_____

Employee Signature