Town of West Brookfield
2 East Main St
West Brookfield, MA 01585

Health Insurance Opt-out Program Application

Thanks for your interest in the health insurance opt-out program. This program is being offered in an effort to reduce the cost of the Town's Health Insurance premium costs.

You will need to submit the following documents as part of the application. Please have them completed and ready to submit.

1. Written documentation of alternative health insurance covered outside of the Town's group plans on employer letterhead
2. Copy of Insurance Card

If you have any questions or trouble filling out the application, please contact the Treasurer/ Collectors office at jpatch@wbrookfield.com or 508-867-1421 opt 3

1. Contact Information

First Name: _____

Last Name: _____

Email Address: _____

Phone Number: _____

2. I certify that I am an active benefit eligible employee for the Town of West Brookfield ("Town"). I hereby acknowledge that I have been advised of my right to enroll in health insurance coverage through the Town of West Brookfield. Having been so advised, I do hereby waive my right to health insurance coverage through the Town and I authorize the Town to cancel my existing health insurance coverage.

☐ Yes ☐ No

3. Date of voluntary cancellation: _____

Town of West Brookfield
2 East Main St
West Brookfield, MA 01585

Health Insurance Opt-out Program Application

4. In order to be eligible for the opt-out program, you must agree to the following:

- **In return for my agreement to waive health insurance coverage, the Town agrees to pay me on a semi annual basis for a total annual payment of two thousand dollars ($2,500.00) for waiving my individual health insurance plan or four thousand ($5,000.00) for waiving my family health insurance plan, whichever applies pursuant to the Town's Health Insurance Opt-Out Policy.**
- **I acknowledge that the Town of West Brookfield is not responsible for any expenses incurred after my insurance termination date for my dependents or myself. Furthermore, my covered dependents and I are not eligible for COBRA continuation coverage.**
- **I understand that the Town of West Brookfield is not responsible for my medical coverage after my termination date (except for medical coverage for injuries and illnesses covered by M.G.L. c. 41, Sec IIIF or M.G.L. c. 152) and for each fiscal year thereafter that I voluntarily agree to waive health insurance coverage through the Town.**
- **I certify that insurance coverage is in force elsewhere for losses in regard to medical conditions for me and my dependents, if any.**

☐ Yes, I agree to the above ☐ No, I do NOT agree to the above

5. I certify and/or agree to the following:

- **There are no outstanding court orders or agreements requiring me to provide health insurance coverage for my spouse, ex-spouse or dependent children, if any.**
- **I hereby acknowledge that I am only eligible to re-enroll in the Town's health insurance plans during the Annual Open Enrollment Period or for a qualifying event. The qualifying events are:**
  - **Marriage or divorce**
  - **Birth or adoption of a child**
  - **Death of a family member**
  - **Lack of other coverage through no fault of the employee or subscriber**
  - **Change in hours, which results in change of employment status**
- **I acknowledge that I may not participate in this plan by switching coverage to a spouse or parent, if they are also an employee of the Town of West Brookfield.**

☐ Yes, I agree to the above ☐ No, I do NOT agree to the above

Town of West Brookfield
2 East Main St
West Brookfield, MA 01585

Health Insurance Opt-out Program Application

6. I understand that to re-enroll, I must complete the required paperwork during the Open Enrollment period or, for a qualifying event, notify the Payroll/Benefits Office and complete the re-enrollment process within thirty (30) days of the date of loss of coverage.

I acknowledge that if I do re-enroll in the Town's group health insurance, if my employment with the Town ends, or if my hours are reduced to below 20 hours per week during the fiscal year, I will only be entitled to payment up to the month containing the date of the employee's separation, re-enrollment or reduction of hours below 20 hours per week.

☐ Yes, I agree to the above ☐ No, I do NOT agree to the above

7. The following documents must be submitted to Payroll/Benefits Department:

Health Insurance Responsibility Disclosure Form (HIRD).

Written documentation of alternative health insurance covered outside of the Town's group plans
and a
Copy of current Insurance Card

8. By signing this document...

I certify I acknowledge that I have read, understand and agree to comply with the terms and conditions of the Town of West Brookfield's Opt-Out Policy.

I understand that false or misleading information given will disqualify me from participating in the health insurance opt-out program.

Employee's Signature: _____

Employee's Name: _____

Date: _____