Health Insurance "Opt-Out Program

1. The Town's active eligible employees who have participated continuously for 24 months in a sponsored health insurance program, whether it be an individual or family plan, have the option to drop their health insurance plan during the open enrollment period commencing in May for health insurance beginning on July 1st. An enrollment period is defined as 12 months commencing on July 1st and ending on June 30th.

2. Employees who drop their insurance shall be eligible to receive a lump sum in the amount defined below in the "Schedule of Payment". This benefit shall be paid each fiscal year on December 1st and June 1st of the current fiscal year.

3. To be eligible to participate in this program, the employee must provide the Town with proof of insurance from another provider (spouse, military, etc.) and complete the Health Insurance Waiver Application and the Commonwealth of Massachusetts Employee Health Insurance Responsibility Disclosure Form.

4. By participating in this program, the employee waives his/her eligibility to receive health insurance from the Town for a two year enrollment period.

5. An employee who decides to participate in this program, and drops his/her health insurance coverage through the Town, may re-enroll in the program during the covered period only if the employee has a qualifying event, as recognized by the health plans' underwriting rules. The qualifying events are:

    a. Marriage or divorce
    b. Birth or adoption of a child
    c. Death of a family member
    d. Lack of other coverage through no fault of the employee or subscriber
    e. Change in hours, which results in change of employment status

    In order to re-enroll in the Town Health Insurance program, the employee must notify the Benefits Coordinator in the Finance Department within thirty (30) days of the qualifying event and provide written documentation of same. If the employee has a qualifying event and needs to re-enroll in the Town's sponsored insurance, the employee's "opt-out" benefit shall be reduced proportionately for the time the employee re-subscribes in the program. The employee's health insurance premiums shall be adjusted so as to recapture any of the "opt-out" benefits for which the employee was not entitled. Any employee who voluntarily terminates their employment after the "opt-out" incentive has been paid will be required to reimburse the Town the applicable, pro-rated amount for the period after termination. This re-payment does not apply to employees retiring from the Town in the current plan year after December 1st.

6. At the next scheduled open enrollment period, the employee who participated in the “opt out program” may select any carrier and plan then offered by the Town for which he/she is otherwise eligible.

7. Employees may not participate in this plan by switching coverage to their spouse or parent, if they are is also an employee of the Town.

8. In order to be eligible for the opt-out program, the employee must have been enrolled in a medical insurance plan for the prior 24 months.

9. The Town Manager may promulgate rules and regulations necessary to implement this program. The continuation of this program will be reviewed annually.

Schedule of Payment

Opt-Out Health Insurance

	Individual	**Family**
Total Benefit	**$ 1,500**	**$3,700**
	Payment (before taxes)**	
December 1,	**$ 750.00**	**$ 1,850**
June 1,	**$ 750.00**	**$ 1,850**

******These payments are eligible to be paid out via deferred compensation plan, on a pre-tax basis, depending if an employee is already enrolled, or contributes less than the maximum allowable by IRS regulations. These payments are not eligible toward Essex Regional Retirement Board pension calculations.

Health Insurance "Opt-Out" Program
Wavier Application

I, _____, in consideration of the sum of $_____, hereby agree to waive my eligibility to obtain health insurance (medical only) from the Town of Hamilton for the period July 1, _____ through June 30, _____.

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 health insurance from another provider.

I further acknowledge that, for the period July 1, _____ to June 30,_____ I am only eligible to re-enroll in the Town's health insurance plans if one of the below listed qualifying events occurs:

a. Marriage or divorce
b. Birth or adoption of a child
c. Death of a family member
d. Lack of other coverage through no fault of the employee or subscriber
e. Change in hours, which results in change of employment status

To re-enroll, I must notify the Town's Benefit Coordinator within thirty (30) days of one of the qualifying events listed above, and will be required to refund the Town any portion of the considered sum above on a pro-rata basis to which I am not entitled due to my failure to complete the current enrollment period.

I further acknowledge that the considerations listed above, less any required withholding, shall be paid to me by the Town in two equal installments on December 1, and June 1 of the plan year.

_____ _____

Signature Social Security Number

_____ _____

Address – Street City, State, Zip Code

Benefit Coordinator Office Use Only

Waiver Received Date _____ Proof of Coverage Date _____

Initials _____ Initials _____

Employee _____ Employee Number _____

Health Plan_____ Ind/Fam _____ Group Number _____

Acceptance Letter Sent _____ Date of Acceptance Letter _____