CITY OF STEPHENVILLE
WAIVER OF GROUP HEALTH INSURANCE

Employee's Names: ***(Last) (First) (Middle)*** **Employee Number**

Home Mailing Address: _____

City **State** **Zip** **Date of Birth**

I hereby certify that I have been given an opportunity to request health insurance under the group medical insurance policy offered by the City of Stephenville, and after careful consideration, I have decided to waive coverage for:

MYSELF or MYSELF & MYDEPENDENTS

Dependents who are waiving:

Name of Dependent	Relationship	Birth Date
_____	_____	___/___/_____
_____	_____	___/___/_____
_____	_____	___/___/_____
_____	_____	___/___/_____

NOTE: Attach copy of ID card for alternate plan to this form.

WAIVER OF COVERAGE

I do NOT elect the medical coverage offered by the City of Stephenville through the current enrollment period due to the fact that I have employer sponsored group health insurance coverage through _____. I understand that by waiving medical coverage, I am not entitled to prescription coverage. I understand that by signing this waiver I am waiving coverage not only for myself, but for my spouse and dependents, if applicable. I hereby decline the health insurance benefits provided by the employee medical insurance plan through the City. The benefits of the plan have been explained to me and I do not desire to participate in the plan.

I understand that this is a binding election until revoked during a future annual enrollment period or by the occurrence of a qualified change in my family status as defined by the regulations issued by the Internal Revenue Service. Notwithstanding the foregoing, however, I understand that if the alternate health insurance coverage I am currently receiving should cease as a result of loss of eligibility or termination of employer contributions (or if it is COBRA coverage which ceases because the coverage period has exhausted), I must notify the City of the termination of the alternate health insurance coverage and request enrollment in the city medical plan within thirty-one (31) days of the termination of coverage in order to become covered under the City's plan. I understand that if I ***do not*** request enrollment within thirty-one (31) days of termination of coverage, I will not be eligible to enroll for any City health coverage until the following annual enrollment which shall be effective the first day of the following plan year.

_____ _____

Employee Signature Date

APPENDIX E
FORM 22