WAIVER OF GROUP HEALTH INSURANCE

_____ _____

Employees Name: (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 & My Dependents

Dependents who are waiving:

Name of Dependents	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 also 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 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 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