TOWN OF NATICK **2023**

HUMAN RESOURCES DEPARTMENT **HEALTH INSURANCE OPT-OUT APPLICATION**

The Town of Natick is offering a health insurance opt-out program for all eligible subscribers enrolled in the Town's health insurance. Please read this form carefully. It is important that you understand all of the terms and conditions before submitting an application.

Subscribers who are eligible and participate in the opt-out program will receive **$2,000 per plan year** for an individual plan or **$4,500 per plan year** for a family plan (or a pro-rated amount depending on date of participation) if they no longer take insurance through the Town and remains an active employee.

☆ To qualify for this program, you must meet all of the following requirements:

1. ***Currently*** be enrolled in a health insurance plan through the Town of Natick for ***at least one year prior to*** the requested date of cancellation

2. Maintain creditable health insurance coverage through a plan not offered by the Town of Natick

_____

Employee/Insured Name (first, MI, Last) Social Security Number

_____

Street Address

_____(_____)_____

City State Zip Phone Number

Health Insurance Provider: ☐ Blue Cross Blue Shield ☐Tufts ☐ Harvard Pilgrim HMO ☐ Harvard Pilgrim PPO

Requested Effective Date: _____/_____/_____ (this is the date your current insurance will be cancelled)

Type of Plan: ☐ Individual ☐ Family

I hereby elect a monetary opt-out payment in lieu of a Town of Natick sponsored group health insurance plan. I understand that the payment will be paid in June of each applicable year. The amount of payment will be pro-rated based upon the cancellation date of my current group health insurance plan with the Town of Natick. *For example, a participant who cancels their insurance for July 1 will be eligible for 100% of the opt-out amount the following June. A participant who cancels their insurance for October 1 will be eligible for 75% of the opt-out amount the following June.*

I certify that I have been enrolled in a health insurance plan through the Town of Natick preceding my requested cancellation date.

I understand that I may cancel this election and reenroll in a Town of Natick's health insurance plan only:

- during annual enrollment periods; or
- after involuntary loss of my other coverage through no fault of my own; or
- through an accepted qualifying event; or
- if a change occurs in family circumstance such as marriage, divorce, birth of a child, or end of spouse's employment; or
- other circumstance as determined by the Town of Natick

I understand that these payments may be considered income, may have tax implications, and that I should consult a tax professional for more information.

I acknowledge that the Town of Natick is not responsible for any expenses incurred after my insurance termination date for my dependents or myself.

I certify that I have creditable health insurance for myself and/or my dependents from a plan sponsor other than the Town of Natick.

I certify that I am in compliance with any applicable court order or agreement requiring me to provide health insurance coverage for my spouse, ex-spouse, or dependent children.

I understand that this program shall end on June 30, 2024 and no opt-out payments shall be paid for participating in this program after that date.

I hereby acknowledge that I have been advised of my rights to enroll in health insurance coverage through the Town of Natick. 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 on the date listed above.

Please return all application to the Benefits Manager, Aimee Carnicelli, Town Hall, 13 East Central Street, Natick, MA 01760.
Aimee Carnicelli can be reached at (508) 647-6411 or acarnicelli@natickma.org

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Printed Name Signature Date