HUMAN RESOURCES
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HEALTH INSURANCE OPT-OUT INCENTIVE PROGRAM

WAIVER FORM DECLINING CITY HEALTH INSURANCE COVERAGE

I acknowledge that I fully understand the health insurance benefits provided by the City of Des Plaines, as well as the health insurance opt-out incentive program. By choosing to opt out of health insurance, I am voluntarily waiving the City's MEDICAL, DENTAL, AND VISION benefit coverage.

Decline Coverage for Plan Year: _____
(Fill-in Calendar Year)

Select the Coverage Tier:

_____ Decline SINGLE Coverage | $2,000 Annualized Value ($83.33 Paid Semi-Monthly)

_____ Decline SINGLE PLUS ONE Coverage | $3,000 Annualized Value ($125.00 Paid Semi-Monthly)

_____ Decline FAMILY Coverage | $4,000 Annualized Value ($166.67 Paid Semi-Monthly)

I understand that if I decline health insurance, I will not be entitled to the same health insurance benefits provided to enrolled City employees for the plan year. Additionally, if I discontinue or decline health insurance, I will not be eligible for COBRA benefits under the City's health insurance plans in the event of my separation from employment with the City. I understand that I may enroll in City health insurance coverage during the plan year if I experience a qualifying life event (e.g., marriage). Furthermore, to receive the waiver payment, I must provide proof of health insurance coverage elsewhere.

Employees who elect to discontinue health insurance will receive waiver payments based on their coverage tier declined. New employees who decline City health insurance will not be enrolled in City coverage and will receive the corresponding coverage tier waiver payments. Proof of dependency is required for new Single Plus One and Family tier coverage waivers.

By waiving participation in the City's health insurance plan, I understand that, outside of a qualifying life event, I can only re-enroll in City health insurance plans during the annual open enrollment period. In the case of re-enrollment due to a qualifying life event, I acknowledge that opt-out payments will stop in the payroll period when City health insurance coverage becomes effective.

I also understand that the City may discontinue the program due to economic reasons or conflicts with Federal or State law, and I should not have any expectations of its continuation. Lastly, I acknowledge that any waiver payments I am receiving will automatically terminate upon my separation from employment with the City.

Employee Signature: _____

Employee Name (print): _____ Date: _____

Please complete for your current MEDICAL insurance coverage.

Insurance Carrier Name: _____

Policy/Group Number: _____ Member ID: _____

Employer/Group Name: _____ Effective Date of Coverage: _____

Subscriber/Member Name: _____ Relationship: _____

Member Services Telephone Number: _____

Name of Person Who Can Verify Coverage: _____

Phone Number of Verifying Person: _____

Coverage Tier (Single, Single Plus One, or Family): _____

ATTACH TO THIS WAIVER FORM (OR UPLOAD) A COPY OF APPLICABLE HEALTH INSURANCE CARD OR A LETTER VERIFYING COVERAGE IN ANOTHER MEDICAL INSURANCE PLAN.

PROOF OF DEPENDENCY IS REQUIRED FOR ALL NEW SINGLE PLUS ONE AND FAMILY TIER COVERAGE WAIVERS.

HEALTH INSURANCE OPT-OUT INCENTIVE WAIVER PAYMENTS

Full-time employees who decline participation in the City's MEDICAL, DENTAL, AND VISION coverage will receive waiver payments, distributed over 24 pay periods (the first two payrolls of each month), as follows:

COVERAGE TIER WAIVED	SEMI-MONTHLY PAYMENT	ANNUALIZED PAYMENT VALUE
Discontinue/Decline SINGLE Coverage	$ 83.33	$2,000
Discontinue/Decline SINGLE PLUS ONE Coverage	$125.00	$3,000
Discontinue/Decline FAMILY Coverage	$166.67	$4,000