Medical Insurance Opt-Out

I request to opt-out the following individuals from the City's medical plan:

Name	Relationship	Date of Birth	Effective Date	Name of other Medical Insurance Plan	HR Use Only

I certify that I meet the following requirements:

1) Have read and acknowledge Policy 502 – Dual Coverage "Opt Out" in the Employee Handbook
2) Have supplied documentation that supports the individuals named below have group medical coverage under another plan, other than my employer sponsored plans.
3) I am eligible to receive contributions into a Standard HRA plan

I understand that individual coverage purchased on the individual market or through the exchange marketplace does not allow me to receive contributions to a Standard HRA Plan. I will notify my employer as soon as possible if a change in coverage occurs and I agree to reimburse any amounts that I received for which I was not eligible.

I understand that re-enrollment in the City's plans is only available during open enrollment each year with coverage effective January 1st of the following year; or anytime during the year if my eligible dependent(s) lose their other medical coverage provided there has been no break in coverage between the end of the other insurance coverage and enrolling on the City plan.

My signature below, I declare that I have read the above, the information is true and correct, and I would like to proceed with opting -out the above mentioned individuals.

Employee Printed Name: _____ Date: _____

Employee Signature: _____