TOWN OF WAYLAND

HEALTH INSURANCE WAIVER PROGRAM

JULY 1, 2016

I, _____, in consideration for the sum of $_____, hereby agree to waive my eligibility to obtain health insurance (medical only) from the Town of Wayland.

I further acknowledge that the consideration listed above, less any required withholding, shall be paid to me in bi-weekly installments.

I hereby acknowledge that my decision not to participate in the Town's health plans is made voluntarily, and that I will provide the Town with proof of insurance from another provider no later than 30 days following my application.

I further acknowledge that I am only eligible to re-enroll in the Town's health insurance plans if one of the below listed qualifying events occurs:

1) Marriage or divorce
2) Birth or adoption of a child
3) Death of a family member
4) Loss of coverage through no fault of the employee or subscriber
5) Change in hours which results in a change of employment status.

To re-enroll, I must notify the Town's Benefits Department within 30-days of one of the qualifying events listed above. Upon re-enrollment, the consideration provided for this health insurance waiver program shall be prorated and reduced and all health insurance waiver installment payments shall cease.

_____ _____

Signature Social Security Number

_____ _____

Street Address City, State, Zip

BENEFITS USE ONLY

Waiver Received: Date_____ Initials_____ Proof of Coverage: Date_____ Initials _____ (Attached)

Health Plan: _____ Individual_____Family_____ Acceptance Letter Sent: _____

Town Employee:

24 Bi-weekly Installments ($75.00) – Individual _____ 24 Bi-weekly Installments ($166.67) – Family _____

School Employee:

24 Bi-weekly Installments ($75.00) - Individual _____ 24 Bi-weekly Installments ($166.67) – Family _____

20 Bi-weekly Installments ($90.00) - Individual _____ 20 Bi-weekly Installments ($200.00) – Family _____