VILLAGE OF HOFFMAN ESTATES

DISCONTINUE/REDUCE/DECLINE VILLAGE HEALTH INSURANCE COVERAGE
For period January 1, 2024 - December 31, 2024

I fully understand the health insurance benefits provided by the Village of Hoffman Estates. also understand the program opting-out from receiving such Village coverage.

I WISH TO DISCONTINUE MY COVERAGE FOR THE COMING PLAN TERM

I WISH TO REDUCE MY COVERAGE FROM A FAMILY TO A SINGLE PLAN

I DECLINE TO ENROLL IN A VILLAGE HEALTH INSURANCE PLAN

☐ I **decline family coverage** ☐ I **decline single coverage**

I understand that if I discontinue/reduce/decline health insurance, I WILL NOT be entitled to the same Health Insurance benefits the Village provides enrolled employees for the coming plan year. I understand that I may re-enroll in a Village plan during a plan year if I have a qualifying life-changing event (i.e., marriage). I also understand that in order to receive the waiver payment I must show alternative health insurance coverage. Participating employees will not have Village health insurance benefits after December 31st of this year. New employees declining Village health insurance will not be enrolled in a Village plan.

By waiving participation in a Village health insurance plan, I understand that, aside from **a** qualifying life-changing event, I can only re-enroll in a Village health insurance plan during the annual open enrollment period with coverage effective January 1 of the next plan year. I understand that under a qualifying event re-enrollment during a plan year, the opt-out payment will cease in the payroll period that Village health insurance coverage becomes effective. I also understand that due to economic reasons or conflicts with Federal or State law the Village may discontinue the program and therefore I shall have no expectations of its continuation.

_____ _____ _____

Employee's Signature Print Name Date

* *

Please complete the following for your* current *health insurance coverage.

Insurance Carrier Name: _____

Policy/Group Number: _____ Effective Date of Coverage: _____

Subscriber/Member: _____

Employer/Group: _____

Person who can verify coverage: _____

Phone Number of Verifying person: _____

ATTACH TO THIS WAIVER FORM A COPY OF APPLICABLE HEALTH INSURANCE CARD OR A LETTER VERIYFYING COVERAGE IN ANOTHER HEALTH INSURANCE PLAN