TOWN OF WALPOLE **HEALTH INSURANCE "OPT-OUT" APPLICATION**

The Town of Walpole 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 **$1,500 per plan year** for an individual plan or **$3,500 per plan year** for a family plan (or a pro-rated amount depending on the date of participation) if they no longer take health insurance through the Town of Walpole.

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 Walpole for at least two consecutive years immediately preceding the requested date of cancellation.
2. Provide proof of insurance for creditable health insurance coverage through a plan not offered by the Town of Walpole.

_____ _____ _____
Employee/Insured Name (First, MI, Last) (Print clearly) Last 4 #'s of Social Security # Work Location

_____ _____
Street Address, Town, State Zip Telephone #

Health Insurance Provider:	**[ ] Network Blue NE**	**[ ] Blue Care Elect PPO**
Requested Effective Date	**_____/_____/_____**	**(this is the date your current insurance will be cancelled)**
Type of Plan	**[ ] Individual**	**[ ] Family**

I hereby elect a monetary allowance in lieu of a Town of Walpole sponsored group health insurance plan. I understand that the allowance will be paid one half the first December pay period and one half of the first June pay period. The amount of payment will be pro-rated based upon the cancellation date of my current group health insurance plan with the Town of Walpole, For example, a participant who cancels their insurance for July 1 will be eligible for 100% of the opt-out amount, one half the first December pay period and one half of the first June pay period. A participant who cancels their insurance for October 1 will be eligible for 75% of the opt-out amount the following time period indicated previously.

I certify that I have enrolled in a health insurance plan through the Town of Walpole for at least two years immediately preceding my requested cancellation date.

I understand that I may cancel this election and reenroll in a Town of Walpole'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 determine by the Town of Walpole

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 Walpole 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 me and/or my dependents from a plan sponsor other than the Town of Walpole.

I certify that there is no outstanding court order or agreement requiring me to provide health insurance for my spouse, ex-spouse or dependent children.

I hereby acknowledge that I have been advised of my right to enroll in health insurance coverage through the Town of Walpole. Having been so advised, I do hereby waive my right to health insurance coverage through the Town and I authorized the Town to cancel my existing health insurance coverage effective on the date listed above.

Please return all applications to Erin McGee, Benefits Coordinator, Town Hall, 135 School Street, Walpole, MA 02081.

_____ _____ _____
Printed Name (print clearly) Signature Date