TOWN OF WELLESLEY
HUMAN RESOURCES DEPARTMENT

HEALTH INSURANCE OPT-OUT APPLICATION

The Town of Wellesley 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 **$2,250 per plan year** for an individual plan or **$4,500 per plan year** for a family plan (or a pro-rated amount depending on date of participation) if they no longer take health insurance through the Town.

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 Wellesley for ***at least two consecutive years immediately preceding*** the requested date of cancellation

2. Maintain creditable health insurance coverage through a plan not offered by the Town of Wellesley

Employee/Insured Name (First, MI, Last) _____ Social Security # _____

Street Address _____

City _____ State _____ Zip _____ ( ) - Phone # _____

Health Insurance Provider:	☐ Harvard Pilgrim HMO	☐ Tufts	☐ Fallon Select	☐ Blue Cross Blue Shield
	☐ Harvard Pilgrim PPO	☐ Fallon Direct		
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 Wellesley sponsored group health insurance plan. I understand that the allowance will be paid in June of each year. The amount of payment will be pro-rated based upon the cancellation date of my current group health insurance plan with the Town of Wellesley. *For example, a participant who cancels their insurance for July 1 will be eligible for 100% of the opt-out amount the following June. A participant who cancels their insurance for October 1 will be eligible for 75% of the opt-out amount the following June.*

I certify that I have been enrolled in a health insurance plan through the Town of Wellesley 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 Wellesley'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 determined by the Town of Wellesley.

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 Wellesley 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 Wellesley.

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

I understand that this program shall end on June 30, 2025 and no allowances shall be paid for participating in this program after that date.

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

Please return all applications to Human Resources, Town Hall, 525 Washington Street, Wellesley, MA 02482.

Printed Name _____ Signature _____ Date _____