

THE BENEFITS OFFICE NEEDS TO HAVE THE ATTACHED WAIVER  
FORMS COMPLETED AND SIGNED FOR OUR 2010 RECORDS.

PLEASE RETURN INFORMATION PROMPTLY.

THANK YOU,

BENEFITS OFFICE

**2010**

**HEALTH INSURANCE WAIVER FORM**

- (1) I hereby voluntarily waive my right to participate in the benefits plan as indicated below in order to receive the annual payment provided.
- (2) I certify that insurance coverage is in force elsewhere for losses in regard to medical conditions for myself and dependents, if any.

NAME OF INSURANCE CARRIER \_\_\_\_\_

GROUP NUMBER \_\_\_\_\_

NAME OF POLICY HOLDER \_\_\_\_\_

TYPE OF COVERAGE \_\_\_\_\_

- (3) I certify that I have carefully read the conditions under which my coverage may be reinstated and rules concerning eligibility for cash payment. These conditions and rules appear on the next page.

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*Employee Signature*

*Date*

**CONDITIONS**

- A. All employees eligible for Medical insurance can participate in the “Health Care Cash Out Option” if the following conditions are met:
- (1) The employee produces evidence of comprehensive group insurance coverage from a source other than the County.
  - (2) The employee is eligible for medical insurance under the County plan.
  - (3) The employee signs on an appropriate form a voluntary waiver not to receive health insurance benefits from the County.
- B. An employee who has waived participation in the County’s health insurance plans for themselves and their dependents, if any, shall not be eligible for any benefits provided by such programs. They shall be able to regain membership in the health insurance plans under the following conditions:
- Note, coverage can be reinstated with no medical evidence under the County Plan if necessitated by change of family status (i.e., marriage, divorce, death of a spouse, birth or adoption of a child and termination of employment of spouse).
- C. An employee who has waived the County Health Insurance plan and terminates employment will be paid any “cash out” monies on a monthly basis according to their termination date.

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**I have read and understand the above. I have explained these conditions to my eligible family members, if any, and I assume full responsibility for this decision.**

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*Employee Signature*

*Date*