PUTNAM COUNTY HEALTH INSURANCE WAIVER FORM

At this time, I choose to waive health insurance coverage offered by Putnam County. I certify that *I am presently covered by the following Health insurance plan*:

_____

Reason for Waiving Coverage - Please Check One:

[ ] Covered through spouse's employer [ ] Covered through a parent's employer
[ ] Under 65 Retiree covered by previous employer's insurance program
[ ] Other Please specify: _____

Please Read and Sign Below:

The plans offered by Putnam County, meet the requirements of Affordability and Minimum Value as required by the Patient Protection and Affordable Care Act (PPACA). In waiving coverage, I understand that I and/or my dependents may enroll under this plan in the future only as the result of certain qualifying conditions (events), for example, within 30 days of involuntarily loss of other group coverage or at the time of my employer's open enrollment period.

I understand that my waiver will remain in effect until I file the appropriate documents with Putnam County as the result of a qualifying event, or during the annual Open Enrollment period and/or in accordance with the Health Insurance carriers' requirements.

_____ _____
Employee Name (PLEASE PRINT) Department

_____ _____
Signature Date

Contract Group:

[ ] CSEA [ ] PBA [ ] PCSEA [ ] PuMA [ ] MGMT [ ] Other

_____ _____
Employer Representative (PLEASE PRINT) Date

_____ _____
Employer Signature Waiver Effective Date