COUNTY AND SHERIFF OF PUTNAM

REQUEST TO DECLINE AND WAIVE HEALTH INSURANCE COVERAGE

1. I, , hereby request a decline and waiver of health insurance provided by the Employer for which I am presently eligible. I understand that I must be covered by another health insurance plan to be eligible for waiver of Employer health insurance coverage. Accordingly, I certify that I am presently covered by the following health insurance plan:

Name of Plan:

Coverage provided by or through:
(Name of organization or employer)

Subscriber Number:

Attached to this form is a copy of the identification card for this health insurance plan.

2. In making this request, I understand and agree that I and/or my dependents will not be eligible, except as indicated above, for Employer provided health insurance coverage for which I and/or my dependents are now eligible for. Notwithstanding anything to the contrary in this form, I understand and agree that I may apply on the form to Request to Resume Health Insurance coverage, and to reestablish Employer provided health insurance coverage and that the effective date for resumption of Employer provided health insurance coverage is subject to and conditioned on the requirements of the health insurance carrier. I hereby acknowledge that I have been advised by the Employer as to the health insurance carrier's present requirements for resumption of health insurance coverage, and I understand that those requirements may be changed at any time by the health insurance carrier. I hereby acknowledge that this form is to be completed annually by me, during the open enrollment period, for the ensuring year.

3. I understand and agree that I will be compensated by the Employer for my waiver of health insurance coverage in accordance with the applicable terms of the collective bargaining agreement detailing this area between the Employer and DSBA.

4. I understand and agree that my waiver of health insurance shall remain in effect unless I apply on the appropriate form to the Employer to discontinue the waiver of health insurance coverage. I understand and agree that the waiver of health insurance coverage shall continue until I complete and file with the Employer the necessary form to reestablish the health insurance coverage provided by the Employer in accordance with the requirements of the Employer's health insurance carrier. The effective date of re-reestablishment of my health insurance coverage shall be as provided by the Employer health insurance carrier. Upon resumption of my health insurance coverage through the Employer, the compensation I have received in connection with waver of health insurance coverage shall cease in accordance with the terms of the collective bargaining agreement by and between the Employer and DSBA.

Date:

Employee Signature_____ Print Name_____
Date

Employer Agent_____ Print Name_____
Date

cc: President, DSBA