



**Town of North Andover
Application for Health Insurance Opt-Out Incentive
FY25 to FY27**

*This form should be completed by active employees of the Town of North Andover and the North Andover Public Schools who have been continuously enrolled in the Town's Health Insurance for twenty-four (24) consecutive months and who wish to opt-out of health coverage completely, or change from a family plan to an individual plan. The terms of the Opt-Out Program are defined in the PEC Agreement. **Employees of the Town and School Department should return their completed forms to their respective Human Resources Department. School Department HR will provide the effective date of cancellation of GIC coverage below and submit the Application to Town Hall HR for processing.***

Employee Name (Please Print): _____

Department (Town or School): _____

For School Department Employees Only: Number of Pay Periods (21 or 26): _____

The chart below indicates the per pay period amount of the opt-out incentive payment. As a reminder, employees who opt-out at any point after July 1 of the fiscal year will receive a prorated amount in accordance with the terms of the PEC Agreement.

Number of pay periods	Family Plan to No Insurance	Family Plan to Individual Plan	Individual Plan to No Insurance
Annual Opt-Out Incentive Payment	\$6,000	\$3,000	\$3,000
26 Pay Periods	\$230.77 per pay period	\$115.38 per pay period	\$115.38 per pay period
21 Pay Periods	\$285.71 per pay period	\$142.86 per pay period	\$142.86 per pay period
Prorated Amount if applicable <i>(For HR Department use only)</i>	\$6,000 multiplied by (number of months without coverage divided by 12), then divided by the number of payrolls remaining in the fiscal year. \$ _____	\$3,000 multiplied by (number of months without coverage divided by 12), then divided by the number of payrolls remaining in the fiscal year. \$ _____	\$3,000 multiplied by (number of months without coverage divided by 12), then divided by the number of payrolls remaining in the fiscal year. \$ _____

As a result of the Affordable Care Act, the Town must obtain a written statement declining health insurance for every employee that has completely withdrawn their health insurance coverage.

If you are declining health insurance coverage completely, please initial here _____.

Employee Signature: _____ **Date:** _____.

If you have any questions, please contact the Town's Human Resources Office by phone at (978) 688-9526, or by email: ssheikh@northandoverma.gov; kmeisinger@northandoverma.gov; kcostello@northandoverma.gov.

(For Human Resources Department Use Only): Effective Date of Cancellation of GIC Coverage: _____