



The Town of Marblehead is now offering a health insurance opt-out program for all eligible subscribers enrolled in the town's health insurance. Please read this form and all terms and conditions of the program before submitting this application.

Subscribers who are eligible and participate in the opt-out program will receive **\$4,000 per plan year** for an individual plan, **\$8,000 per plan year** for a family plan, or a **prorated amount** based on date of participation in the program.

To qualify for this program, you must meet both of the following requirements:

1. Currently be enrolled in a health insurance plan through the Town of Marblehead for at least two consecutive years immediately preceding the requested date of cancellation.
2. Maintain and provide proof of creditable health insurance coverage through a plan not offered by the Town of Marblehead.

Employee/Insured Name (First, MI, Last)		Social Security #	
Street Address			
City	State	ZIP	Phone # ()
Department	Position	Requested Effective Date	

I hereby elect a monetary allowance in lieu of a Town of Marblehead employer-sponsored group health insurance plan. I understand that the allowance will be paid through payroll once per plan year based on my date of participation in the program. The amount of the payment will be pro-rated based upon the cancellation date of my current group health insurance plan with the Town of Marblehead. *For example, a participant who cancels their insurance by April 30th of each year through the Town of Marblehead's Open Enrollment period will be eligible for 100% of the opt-out amount but a participant who cancels via a qualifying event by September 30th would be eligible for 50% of the opt-out amount.* Recurring payments will be made in September each year thereafter. **Please see the table on page 2 of this form for the current health insurance opt-out proration and payment schedule.**

I certify that I have been enrolled in a health insurance plan through the Town of Marblehead for at least two years immediately preceding my requested cancellation date.

I understand that I may cancel this election and re-enroll in a Town of Marblehead 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 Marblehead.

I understand that these payments may be considered income, be subject to applicable payroll taxes and withholdings, and that I should consult a tax professional for more information. Opt-out payments are not retirement-eligible.

I acknowledge that the Town of Marblehead 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 Marblehead and will provide proof of such coverage with this application.

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, 2028 and no allowances shall be paid for participating after that date.

I understand I am required to submit the required forms to drop my insurance as well as proof of other coverage/qualifying event to the GIC in addition to submitting this form and proof of other creditable coverage to the Town of Marblehead.

I hereby acknowledge that I have been advised of my right to enroll in health insurance coverage through the Town of Marblehead. 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 **or as determined by the GIC.**



TOWN OF MARBLEHEAD
HUMAN RESOURCES & PAYROLL DEPT

HEALTH INSURANCE OPT-OUT APPLICATION

Please return all applications to the Payroll office at the Mary Alley Municipal Building, 7 Widger Road, Marblehead, MA 01945.

Employee/Insured Signature

Date

Health Insurance Opt-Out Proration and Payment Schedule:

Notice Received By	Percentage of Payment	Payment Issued
April 30 th	100%	September
May 31 st	90%	October
June 30 th	80%	October
July 31 st	70%	October
August 31 st	60%	October
September 30 th	50%	December
October 31 st	40%	December
November 30 th	30%	March
December 31 st	20%	March
January 31 st	10%	March

Please note: Applications and proof of other coverage received in the months of February or March will not be eligible for payment for that plan year; the first payment would be 100% issued in September for the following plan year.

Please reach out to Benefits Coordinator Amanda Vieceili or Payroll Manager Kathy Carey at 781-631-1705 or payroll@marbleheadma.gov with any questions or to submit your application and documentation.

– For Department Use Only –

Employee ID #: _____ Date of Hire: _____ Original Enrollment Date: _____

Health Insurance Plan: _____

Individual Plan ☐ Family Plan ☐ Proof of Other Insurance Provided (retain copy with this form): **Y** or **N**

Qualifying Event: ☐ TOM Open Enrollment ☐ Other (please specify): _____

GIC Termination Date: _____ Date Opt-Out Request Received by Town: _____

Opt-Out Percentage: _____ % First Annual Payment Due to Employee: _____ / _____ (MM/YYYY)



Application Approved by (please print): _____

Signature: _____ Date: _____