City of Laconia
HEALTH INSURANCE WAIVER

I,_____, am a City of Laconia employee eligible for the City's group health insurance and elect not to enroll in the City's plan for the fiscal year **2016/2017.**

I understand and agree to the following:

I anticipate having health insurance coverage for the above fiscal year under my spouse's or parents plan through his/her employer. (Please list employer name and contact)

_____

_____

The opt-out payment will not apply if I am covered under an individual insurance plan or through a government exchange plan.

I am required to provide the City of Laconia proof of other health insurance coverage by supplying a copy of my health insurance card.

My spouse is not employed by the City of Laconia, which includes the School Department and Water Works.

If, by proof of coverage under my other plan, I do not participate in the City's health insurance plan during the fiscal year listed above, I will receive a taxable stipend paid at the end of each fiscal quarter. If I opt out of the City's plan during the fiscal year, that year's quarterly payments will be pro-rated.

If a qualifying event occurs where I am no longer eligible for coverage under the non-City plan, I must notify the Personnel Specialist in writing within thirty (30) days, at which time this stipend agreement will terminate.

I understand that reinstatement of the health insurance benefit will require that a qualifying event specified by the health insurance carrier is satisfied. Re-entry for any reason other than a qualifying event specified by the insurance carrier can only take place on July 1st.

I shall hold the City harmless of any error or omission on my part for failure to notify Personnel in writing within thirty (30) days of a qualifying event in which I should have been enrolled under the City's group health insurance plan.

If I am no longer employed by the City at the end of the fiscal quarter when opt-out payments are issued, I will not receive any stipend for the quarter in which I terminated.

This agreement will expire on June 30th of the fiscal year shown above. Renewal is not automatic. Application for Health Insurance Stipend with proof of other coverage must be submitted before July 1st each year.

_____	_____	_____
Employee signature	Date of hire	Date
_____	_____	
Personnel Specialist	Date	