

Request to Decline Health Insurance Coverage

NOTICE: HIPAA SPECIAL ENROLLMENT RULES

If you are declining enrollment in the town's health insurance program for yourself and your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

"I have been informed of my eligibility to enroll in the Town of East Longmeadow's health insurance program. I am declining health insurance coverage for myself and my dependents (if applicable). I have read the Special Enrollment Rules described above and I have been provided with a copy of the Special Enrollment Rules."

HEALTH INSURANCE

The dollar amount of the employee's portion of the monthly premium cost of the least expensive individual health plan offered by the Town of East Longmeadow for FY 2027 is **\$270.90**

On behalf of myself and my eligible dependents, if any, I waive the options to enroll in the Town of East Longmeadow's contributory group health plans offered at this time for the following reason:

- I am covered under another group plan as a spouse or dependent
- I am covered by Medicare or Veterans Program
- I have purchased subsidized coverage through state or federal Exchange
- I am covered under another group plan sponsored by a second employer
- I am covered under a group plan as a spouse or dependent of an East Longmeadow employee
- I am covered through an Individual plan or purchased coverage through state or federal Exchange with no subsidy
- I do not wish to participate in health care benefits at this time. (I am declining health insurance entirely)

Please provide the following information for your coverage:

Subscriber Name: _____

Carrier Name: _____ Group #: _____

EMPLOYEE AFFIDAVIT

I hereby affirm, under the penalties of perjury, that all the information provided herein is true to the best of my knowledge. I also understand that if I do not have health insurance I may be responsible for the full costs of all medical treatment and that I may incur tax penalties on the State and Federal levels.

Signature of Employee

Date

Name

Position