<u>WAIVER OF BENEFITS</u>

Effective July 1, 2023

I wish to [ ] **waive** the insurance benefits offered, **or** [ ] **extend my waiver** of benefits, I understand that by executing this waiver I am not entitled to any insurance benefits and that should I elect to be reinstated to the insurance plan; all coverage would be subject to any regulations or restrictions, including waiting periods, which may be prescribed by the appropriate insurance carriers. Reinstatement is also subject to the rules and regulations of the Internal Revenue Service and the Town of Plainville Flexible Benefits Plan (IRS Code § 125). I fully understand this election to waive insurance benefits and I make this election freely and without any undue influence from my employer, its agents or employees.

Please provide the following information:

I am:

☐ Single

☐ Married/civil union **(DEPENDENT STATUS VERIFICATION FORM must be completed.)**

Dependent Information:

☐ I have no dependents

☐ I have [ ] dependents **(DEPENDENT STATUS VERIFICATION FORM must be completed.)**

_______________________	_______________________	_______________
Employee Name	**Signature**	**Date**

- -

RECEIPT OF WAIVER

UPON RECEIPT OF YOUR WAIVER, HUMAN RESOURCES WILL EMAIL CONFIRMATION OF RECEIPT OF YOUR WAIVER.

Teachers: Please make sure you receive the EMAIL confirmation, which you will need to receive the appropriate waiver stipend, if applicable.

DEPENDENT STATUS VERIFICATION

(For Qualifying Events -OR- Benefits Waiver)
Town of Plainville – July 1, 2023

[ ] New Hire [ ] Change [ ] New to Insurance (already employed) [ ] Waiver of Insurance

All employees must complete this affidavit prior to enrolling dependents onto Plainville's medical insurance plan, or upon submission of waiver of benefits. If you are a new hire, please check **"New"** in the upper-left corner and complete all sections listing all dependents in Part 2. For a **"Change,"** complete all sections of Part 2 to add your new dependent, or, if changing insurance plans complete all information listing all dependents. For a "**Waiver,**" please complete all sections of Part 2 listing **all** dependents. **Please print clearly. Incomplete and/or illegible forms will be returned.**

Part 1 - Employee Information

Last Name:_____ First Name:_____

Part 2 - Dependent Information - Please list dependents and date of birth **(including spouse).**

Dependent First & Last Name (include spouse)	Date of Birth	Qualifying Event *	Date of Qualifying Event *
1)			
2)			
3)			
4)			
5)			
6)			

***Qualifying Events**: Marriage, civil union, birth, adoption, medical child support order, court order (guardian).

Dependent Child: Must be either an unmarried dependent child under age 26, unmarried student dependent child under age 26, or disabled dependent child (Anthem BC/BS reserves the right to require proof of dependent child status).

Part 3 – Authorization

I certify the above information to be correct, complete, and true to the best of my knowledge. I acknowledge that any false and/or incomplete responses or statements may result in rescission of coverage and/or non-payment of claims for me or my eligible dependents, and the employer may bring action against me to recover their losses, including attorneys' fees, and/or may result in disciplinary action up to and including termination.

Employee's Signature:_____ Date: _____

NOTE: Please remember, an Anthem enrollment form (or insurance waiver form) must be completed and submitted to add your dependents to your medical insurance plan or to cancel from your medical insurance plan (or to waive it).

Return completed forms to the Human Resources Office