Health Insurance Opt-Out Waiver Incentive Form

Employee Name (please print): _____ **Department:** _____

☐ **I elect the Health Insurance Opt-Out Waiver Incentive for the current health plan year. I have other qualifying medical insurance and will provide proof of other coverage to receive the waiver incentive funds.**

Other Insurance Subscriber Name: _____
Relationship to you: ☐ parent ☐ spouse ☐ other _____
Other Insurance Name: _____

I understand that by signing this form, I am waiving coverage on the City of Salem's health insurance plans for myself and all my eligible tax dependents for the current health plan year. I certify that, as of January 1, all my tax dependents and I will be enrolled in other qualifying health insurance coverage that is deemed to be minimum essential coverage under the Affordable Care Act. **Proof of other coverage is required.**
I understand that I will not be able to revoke this waiver and elect coverage on the City of Salem's medical, vision, and dental plans until the next open enrollment period, for coverage effective the first of the following calendar year, unless I experience, and provide timely documentation of, a qualifying event within 30 days of the qualifying event date. Qualifying events include:

- Loss of other coverage. I can enroll myself, and each dependent that loses other coverage. This does not apply if I lose coverage because I failed to pay premiums timely or if coverage is terminated for cause.
- Experience a qualifying change in status, including marriage, divorce, a change in my or my spouse's employment status, or my spouse's open enrollment.
- Acquire a new dependent through marriage, birth, adoption, or placement for adoption. If I acquire a new dependent, I can enroll myself and each of my new dependents.

I understand that the opt-out incentive shall not be used to purchase other health insurance in the Marketplace, a state exchange, or through the individual insurance market. I understand that the City's opt-out incentive contribution to the HRAVEBA or HSA shall not be considered part of base pay for overtime calculations.

I elect to have my Opt-Out Incentive contributed to the ☐ HRAVEBA or ☐ Health Savings Account (HSA)*
*Elect the HSA only if you are certain you meet IRS requirements for HSA contributions such as your current health insurance plan is a High Deductible Health Plan.

Email Address for Administrator contact: _____

Opt-Out Incentive Provisions
Benefit eligible City of Salem employees who opt-out of all City-sponsored health insurance plans (medical, vision, and dental) the City will contribute $225 per month to an HRAVEBA or Health Savings Account (HSA) for a full-time career employee and a pro-rated amount for a part-time career employee. To be eligible for this opt out incentive, all of the following below conditions must be met:

1. Must be a health insurance benefit eligible employee.
2. The employee and dependents must be enrolled in another employer's group health plan (e.g. a spouse's employer group plan) that provides minimum essential health coverage as required by the Affordable Care Act, and the employee must provide documentation of such enrollment upon each annual opt-out election and upon City request;
3. The employee and dependents must not use HRAVEBA or HSA funds to purchase a health plan in the Marketplace, a state exchange, or through the individual insurance market;
4. The employee cannot revoke the opt-out election until the next open enrollment period for the coverage in the following calendar year, unless the employee experiences and provides timely notice and documentation of a qualifying event, including loss of other employer group health insurance coverage, a qualifying status change, or the acquisition of a new dependent.
5. The employee must sign a waiver each year agreeing to these conditions.

Employee Signature: _____ **Date:** _____
I certify that I have read, understand, and agree to the information above. My signature indicates that I have elected to waive all of the City's health insurance coverage for myself and all my tax dependents.

Employer Use Only

Employee #: _____ Division/BU: _____
☐ Approved Employee waiver incentive effective date: _____
☐ New Opt-Out: ☐ New hire/date: _____ ☐ QE reason/date: _____
☐ Renewal Opt-Out/Open Enrollment

HR Representative: _____ **Date:** _____

Proof of insurance documentation received: ☐
FTE: Full-time ☐ or Part-time ☐ _____ FTE
Per paycheck $ _____ Per month $ _____
HRAVEBA: Oracle B009 ☐ HRAVEBA system ☐
HSA (HDHP other ins): HSA Form ☐ Oracle B050 ☐ BOA system ☐
Update Health Insurance Waiver tracking list: ☐
Oracle FIMS ACA Decline Coverage: ☐