TOWN OF NORTH ATTLEBOROUGH
Health Insurance Opt-Out Incentive Election Form

_____
(Please Print) Name: First MI Last

_____
Street Address City, State Zip Code

_____
Job Title & Department

1. I hereby elect a monetary incentive in lieu of participating in a group health insurance plan offered through the Town of North Attleborough. I understand the incentive will be paid quarterly, provided I remain off the Town's group health insurance for the entire quarter. I understand that these payments will be made after the end of each applicable quarter and through direct deposit, subject to applicable withholdings.

2. I was covered by the Town of North Attleborough's health insurance plan for a minimum of 24 months prior to making this election and that coverage remains active at present.

   Type of coverage: _____ Individual _____ Family

   Plan Enrolled in: _____ HMO _____ PPO

3. I have compared the alternate health insurance coverage under which I (for individual plans) and my dependents and/or spouse (for family plans) will be covered when I opt out of Town coverage. The alternate coverage is comparable to the coverage I/we have with the Town and satisfies the requirements of MassHealth and the Affordable Care Act. I

   I have enclosed proof of coverage:

   ___ for myself (individual plan) or ___ for me and my spouse and/or dependents (family plan).

4. I am <u>not</u> subject to a court order or judgment or agreement requirement that I provide health insurance coverage for my spouse, ex-spouse and/or dependent children. _____ (please check)

5. I understand that I may cancel this election only if:
   - I involuntarily lose my alternate health coverage through no fault of my own;
   - There is a change in my family status (e.g., marriage, divorce, birth or adoption of a child);
   - My spouse's employment terminates, or my spouse's hours of work are reduced resulting in the loss of my alternate health insurance coverage;
   - I choose to re-enroll in the Town's group health insurance during the annual open enrollment period.

By signing below, I acknowledge that I have read all of the provisions in the Town of North Attleborough Health Insurance Opt-Out Incentive Program, I understand them fully, I agree to comply with them, and I am electing a monetary incentive in lieu of participating in a health insurance plan offered through the Town of North Attleborough.

_____
Signature of Insured Date

For Town Use Only

Town Insurance Terminated	☐ Effective Date: _____	_____	☐ Date: _____
Benefit Tracker Updated	☐ Date:_____	_____	☐ Date: _____
BUY-OUT PERIOD	☐ ___, 2025– ____ 20___	INCENTIVE	☐ Individual $1,000/quarter ☐ Family: $1,500/quarter