Town of Plaistow, New Hampshire

Human Resource Department

Plaistow Town Hall
145 Main Street
Plaistow, NH 03865

(603) 382-5200 X 204 Office
(603) 382-7183 Fax
Web: www.Plaistow.com

Conditional Medical Waiver Form

If you and your tax dependents are covered under another employer-sponsored group health insurance plan that provides minimum essential coverage in accordance with the Affordable Care Act, you may waive medical coverage and receive an opt-out payment.

To be eligible for the opt-out payment, you must attest that you and all of your tax dependents are enrolled in other group health coverage that provides minimum essential coverage. Although the opt-out payment can be used for any purpose, it is intended to be a form of reimbursement for other health insurance coverage and is taxable.

Date: _____ Employee ID: _____

Department:_____ Position: _____

Employee Name (Last, First MI): _____

Department: _____

Name(s) of Dependents:_____
(Include spouse, if applicable) _____
_____

Medical Coverage Provided By
(Employer Name) _____

Name of Medical Coverage Provider *(Anthem Blue Cross Blue Shield, Cigna, Harvard Pilgrim, etc.)*

_____

Policy/Group Number:

_____

Effective Dates of Coverage: _____

Please provide the Town of Plaistow Human Resources Department a copy of your current insurance card(s) for you and eligible dependents, if applicable. ☐ **Card(s) Received**

Certification

I certify that I have been given the opportunity to elect affordable, minimum essential health coverage from the TOWN OF PLAISTOW and that by signing this form and receiving the opt-out payment I am waiving coverage for myself and my eligible dependents (if applicable). I understand that I will not be eligible to enroll in the TOWN OF PLAISTOW health plan until the next open enrollment period unless I experience a family status change or qualifying event.

I further certify that I and all of my eligible dependents (for whom I am waiving coverage) are enrolled under other affordable employer-sponsored group health minimum essential coverage.

Employee Signature: _____ Date: _____