Application for Waiver of Medical Coverage & Evidence of Coverage Affidavit

Plan Year January 1, 2017 – December 31, 2017

I acknowledge that I and my expected tax family members+ must maintain minimum essential health coverage+, other than individual coverage, to receive payment from Douglas County for opting out of County sponsored health insurance medical coverage. I understand that I may be required to provide proof of coverage and other information as requested by Human Resources.

For Plan Year 2017, the monthly contribution provided in lieu of medical coverage will be $350.00 per month, from which the cost of dental, vision, and life insurance will be deducted each month.

I agree to indemnify and save and hold harmless the County, its agents, and its employees from any and all claims, causes of action, or liability arising from the applicant's acceptance of the benefits of this waiver, including, but not limited to, any claim, dispute, or litigation of any kind arising from my comparable insurance coverage with another carrier.

I acknowledge and agree that waiving medical coverage provided by the County is entirely voluntary and that upon revocation of any waiver, I may be eligible to obtain medical coverage through the County under the terms of coverage provided by the County's carrier, including provisions relating to enrollment dates and eligibility.

In accordance with the above, I certify and understand the following:

☐ As of 1/1/2017, I and my tax family members will be enrolled in minimum essential health insurance coverage, other than individual coverage, through:

☐ Coverage under my spouse/domestic partner's plan – name of carrier: _____

☐ Other coverage – specify type and name of carrier: _____

☐ No monthly contribution in lieu of medical coverage will be made if Douglas County has reason to know that I or any other member of my expected tax family does not have, or will not have, the required alternative coverage.

I acknowledge that in the event I no longer meet the criteria to waive medical coverage set forth above, I will no longer be eligible for a monthly contribution in lieu of medical coverage and will immediately notify Human Resources.

By signing below, I acknowledge and agree to the above terms and certify that I am voluntarily applying to waive medical coverage available to me through Douglas County.

Employee Name	Date of Birth

Signature	Date

+ As defined by law.