CITY OF WAUPACA
"OPT-OUT"
MEDICAL PLAN WAIVER FORM

Please Print or Type
Company: _____Department: _____

Employee Name: _____SS#: _____

Street Address: _____

City: _____ State: _____ Zip: _____

I hereby elect not to participate in a Medical Plan beginning on _____. I am electing to receive medical insurance coverage under my spouse's employer's plan or another non-city group medical plan and I am providing the identifying information on the alternate medical plan below and have attached a copy of my medical plan identification card.

The incentive shall be a maximum amount of 3900.00 per calendar year. Employees may elect to have the opt-out funds deposited into Wisconsin Deferred Compensation biweekly and are subject to the rules governing the plan or added to their paycheck as taxable income biweekly.

I understand that I cannot change or revoke this agreement any date prior to the next plan year unless I have a significant change in family status as described in the enrollment materials.

I understand that every year during open enrollment, I have the option to re-apply for medical insurance or continue in the Opt-Out Benefit for the following Plan Year.

COMPLETE IN FULL & ATTACH COPY OF MEDICAL ID CARD:

Spouse's Name: _____

Spouse's Employer: _____

Alternate Medical
Plan Administrator/ Alternate Medical
Insurance Carrier: _____ Plan Group #: _____

Employee's Signature: _____

Employer's Agent Signature: _____ Date: _____

☐ I elect to have funds deposited in Wisconsin Deferred Compensation.

☐ I elect to have funds added to my paycheck.