LakeCounty

Revision 10-2012

Medical Insurance Waiver / Cancellation

Employee Name: _____ Employee ID#: _____

SSN (Last 4 Digits Only): _____ Department: _____

WAIVER REQUEST

Benefit Enrollment Form required

I have been given the opportunity to enroll in one of the group medical insurance plans provided by Lake County and, after careful consideration, have decided not to enroll at this time.

Signature: _____

Date: _____

CANCELLATION REQUEST

Benefit Enrollment Form and proof of qualifying event required

Please cancel my:
____Single medical coverage
____Single Plus One medical coverage
____Family medical coverage

Signature: _____

Date: _____

Please read and initial the following:

____I understand that I must provide proof of alternate medical insurance coverage in order to cancel or waive my participation in Lake County's group medical insurance.

____I understand that, if I meet the qualifications, by waiving my right to participate in Lake County's medical insurance I am eligible for the County's Opt-out Program ($57.69 per pay period, paid on a bi-weekly basis as part of the normal paycheck process).

____I understand that if I am receiving an Opt-out premium and I terminate employment or retire, no further Opt-out premium payments will be issued.

____I understand that in the event I decide to apply for coverage for myself or myself and my dependents at a later date, application for coverage will be delayed until the next open enrollment period unless a HIPAA (Health Insurance Portability and Accountability Act) qualifying enrollment event has occurred, and that I will have to submit proof of insurability in order to obtain medical coverage with Lake County's group medical provider. A qualifying enrollment event is defined as marriage, birth or adoption of a child, or loss of eligibility for other insurance coverage including divorce or legal separation, death, termination of employment or reduction in hours of employment. To enroll, a Benefit Enrollment Form must be submitted to Human Resources within 30 days of the qualifying event, unless birth/adoption of a child which allows 60 days.

____I understand that if I lose coverage under a medical plan outside of Lake County, get married, or have a child, I may apply for Lake County's group medical insurance, subject to proof of insurability requirements. The effective date of the coverage will be determined based on the usual procedures for establishing coverage under the medical plan. If I am reinstated during the calendar year, any medical premiums will be deducted from my paycheck as provided under the medical plan.

____The Opt-out program is being offered to benefit eligible employees who have alternate medical insurance coverage and also to benefit Lake County as a method of managing the cost of providing medical insurance benefits. I understand that I should verify with Human Resources that I am eligible to participate. Certain situations may exclude me from eligibility.

____I certify that my spouse is not a Lake County or Forest Preserve employee.

___ I certify that I am not a Local 150 union member.

____I certify that I have read the provisions contained in this form.

Signature: _____

Date: _____

Human Resources Use Only:

Verification of other insurance received:
____Yes, attached ____No

Waiver Payment Effective: _____

Cancel Insurance Effective: _____

Generalist Signature: _____