TOWN OF HOLLISTON
HEALTH INSURANCE OPT-OUT APPLICATION

Fiscal Year 2024
July 1, 2023 thru June 30, 2024

_____
Employee/Insured Name (first, MI, Last) Social Security Number

_____
Street Address

_____(_____)_____
City State Zip Phone Number

Health Insurance Provider: ☐ Harvard Pilgrim HMO ☐ Tufts ☐ Blue Cross Blue Shield ☐ Harvard Pilgrim PPO

Requested Effective Date: _____/_____/_____ (this is the date your current insurance will be cancelled)

Type of Plan: ☐ Individual ☐ Family

I hereby elect a monetary opt-out payment in lieu of a Town of Holliston sponsored group health insurance plan. I understand that the payment will be paid in June of each applicable year as noted above.

I certify that I have been enrolled in a health insurance plan through the Town of Holliston preceding my requested cancellation date.

I understand that I may cancel this election and reenroll in a Town of Holliston's health insurance plan only:

- during annual enrollment periods; or
- after involuntary loss of my other coverage through no fault of my own; or
- through an accepted qualifying event; or
- if a change occurs in family circumstance such as marriage, divorce, birth of a child, or end of spouse's employment; or
- other circumstance as determined by the Town of Holliston

I understand that these payments may be considered income, may have tax implications, and that I should consult a tax professional for more information.

I acknowledge that the Town of Holliston is not responsible for any expenses incurred after my insurance termination date for my dependents or myself.

I certify that I have creditable health insurance for myself and/or my dependents from a plan sponsor other than the Town of Holliston.

I certify that I am in compliance with any applicable court order or agreement requiring me to provide health insurance coverage for my spouse, ex-spouse, or dependent children.

I understand that this program shall end on June 30, 2024 and shall "sunset" on that date unless extended by mutual agreement of the parties.

I hereby acknowledge that I have been advised of my rights to enroll in health insurance coverage through the Town of Holliston. Having been so advised, I do hereby waive my right to health insurance coverage through the Town and I authorize the Town to cancel my existing health insurance coverage on the date listed above.

Please return this application with your health insurance termination form to Human Resources, Town Hall, 703 Washington Street, Holliston, MA 01746 or email forms to benefits@holliston.k12.ma.us. Cheryl Houle can be reached at (508) 474-3335 or houlec@holliston.k12.ma.us

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Printed Name Signature Date

03/2023