REQUEST TO DECLINE AND WAIVE MEDICAL HEALTH INSURANCE COVERAGE

(Medical Buy-Out) - 2016 Enrollment Form

I,_____, as a benefits eligible employee, have been offered enrollment in ***County of Orange*** sponsored health benefits that meet the Affordable Care Act requirements of both affordability and minimum value standards. However, I hereby request to decline and waive my enrollment in ***County of Orange*** sponsored medical health insurance for the 2016 Plan Year (Jan. 1 – Dec. 31, 2016).

I understand that during the Plan Year 2016, I must be continuously covered by another ***employer based*** medical health insurance plan. I am requesting enrollment in the ***2016 Orange County Medical Buyout***, subject to the rules and regulations of the plan.

Accordingly, I hereby certify that I will have coverage under the following medical health insurance plan for 2016:

Name of Health Insurance Plan for 2016: _____

This Coverage Belongs to: (Name of Plan Holder/Relationship) _____

Source of Coverage: (Employer Name) _____

Last 4 digits of your Social Security Number : xxx-xx_____

Last 4 digits of the Plan Holder's Social Security Number : xxx-xx_____

Will all of your dependents, if any, have coverage under the above Plan? Yes____ No____

Is your spouse employed byO.C. Government or O.C.C.C. : Yes____ No____

In making this request for 2016, I understand and agree that I and/or my dependents will not be eligible for ***County of Orange*** provided medical health insurance coverage for which I and/or my dependents would otherwise be eligible. Notwithstanding anything to the contrary in this form, I understand and agree that if I suffer an involuntary loss of this alternate coverage, I may apply to enroll in ***County of Orange*** medical health insurance coverage.

I understand and agree that my ***Request to Decline and Waive Medical Health Insurance Coverage*** shall remain in effect throughout the 2016 calendar year unless I suffer an involuntary loss of alternate coverage. In order to enroll in the medical health insurance coverage provided by the ***County of Orange***, I understand that I must complete and submit to the Office of Risk Management a "Request to Resume Medical Health Insurance Coverage" and provide proof of the involuntary loss of coverage along with ***a completed Change of Circumstance form***. The effective date of my medical health insurance coverage shall be subject to and conditioned on the requirements of the Employer's medical health insurance carrier(s) and the Office of Risk Management.

Employee Signature _____ **Date:** _____

Print Name_____

APPROVED BY Risk Management: Yes _____ No _____ Date_____

Risk Management 18 Seward Avenue Middletown, New York 10940 845/615-3600