REQUEST TO DECLINE AND WAIVE MEDICAL HEALTH INSURANCE COVERAGE

(Medical Buy-Out) - 2014 Enrollment Form

1. I,_____, as an active benefits eligible employee, hereby request to decline and waive my Employer sponsored medical health insurance for the 2014 Plan Year (Jan. 1 – Dec. 31) I understand that, during Plan Year 2014, I must be continuously covered by another medical health insurance plan to be eligible for waiver of Employer sponsored medical health insurance coverage. Accordingly, I hereby certify that I will have coverage under the following medical health insurance plan for 2014:

Name of Health Insurance Plan for 2014: _____

This Coverage Belongs to: (Name of Enrollee) _____

Source of Coverage: (Employer Name) _____

Your S. S. # :_____-_____-_____ **Your spouse's S. S. # :** _____-_____-_____

Your spouse's Name:_____

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

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

2. In making this request for 2014, I understand and agree that I and/or my dependents will not be eligible for Employer 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 re-establish Employer provided medical health insurance coverage, as described in Item. 4, explained below.

3. I understand and agree that I will be compensated by the Employer for my waiver of medical health insurance coverage in accordance with the terms of the applicable collective bargaining agreement.

4. I understand and agree that my waiver of medical health insurance coverage shall remain in effect throughout the 2014 calendar year unless I suffer an involuntary loss of alternate coverage. In order to re-establish the medical health insurance coverage provided by the Employer, 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. The effective date of re-establishment 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. In addition, I understand that these requirements may be changed at any time. If I submit the form "Request to Resume Medical Health Insurance Coverage" to the Office of Risk Management, and my request is granted, I agree to forfeit the buy-out payment due me for the quarter in which I resume medical health insurance coverage, and thereafter.

Employee Signature _____ **Date:** _____

Print Name_____

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APPROVED BY Risk Management: Yes _____ No _____ Date:_____

Risk Management, 18 Seward Avenue, Middletown, NY 10940 Telephone 615-3600
Revised 11/08; 9/09, 6/10, 10/10, 9/11, 9/12, 9/13