



**CITY OF SOMERVILLE, MASSACHUSETTS**  
**JOSEPH A. CURTATONE**  
**MAYOR**

**Voluntary Waiver of Health Insurance**  
**For Enrollment in Opt-Out Program**

I, \_\_\_\_\_, am an active employee for the City of Somerville ("City") and was covered by a City health insurance plan. I hereby acknowledge that I have been advised of my right to enroll in health insurance coverage through the City of Somerville. Having been so advised, I do hereby waive my right to health insurance coverage through the City and I authorize the City to cancel my existing health insurance coverage as of:

Date of Voluntary cancellation: \_\_\_\_\_

- In return for my agreement to waive health insurance coverage, the City agrees to pay me on a monthly basis for a total annual payment of two thousand dollars (\$2,000.00) for waiving my individual health insurance plan or four thousand (\$4,000.00) for waiving my family health insurance plan, whichever applies.
- I acknowledge that the City of Somerville is not responsible for any expenses incurred after my insurance termination date for my dependents or myself. Furthermore, my covered dependents and I are not eligible for COBRA continuation coverage.
- I understand that the City of Somerville is not responsible for my medical coverage effective on (except for medical coverage for injuries and illnesses covered by M.G.L. c. 41, § III F or M.G.L. c. 152) and for each fiscal year thereafter that I voluntarily agree to waive health insurance coverage through the City.
- I hereby acknowledge that I am only eligible to re-enroll in the City's health insurance plans during the Annual Open Enrollment Period or for a qualifying event. The qualifying events are:
  - Marriage or divorce
  - Birth or adoption of a child
  - Death of a family member
  - Lack of other coverage through no fault of the employee or subscriber
  - Change in hours, which results in change of employment status

To reenroll, I must complete the required paperwork during the Open Enrollment period or, for a qualifying event, notify the City Personnel Department and complete the re-enrollment process within thirty (30) days of the date of loss of coverage.

- I acknowledge that if I do re-enroll in the City's group health insurance, if my employment with the City ends, or if my hours are reduced to below 20 hours per week during the fiscal year, I will only be eligible for a pro-rated payment through the date prior to such re-enrollment, separation from employment, or reduction in hours.
- I acknowledge that I may not participate in this plan by switching coverage to a spouse or parent, if they are also an employee of the City of Somerville.
- I acknowledge that I have read and agree to comply with the terms and conditions of the City of Somerville's Opt-Out Policy.

\_\_\_\_\_  
Employee name/Employee signature

\_\_\_\_\_  
William Roche, Director of Personnel

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date