TOWN OF BERKLEY
MASSACHUSETTS

OFFICE OF THE TREASURER/COLLECTOR
www. townofberkleyma.gov

Health Insurance Opt-Out Policy

The Town of Berkley will now offer a health insurance opt-out program for all active eligible subscribers enrolled in the Town's health insurance. **Please read this form carefully**. It is important that you understand all of the terms and conditions before submitting an application.

Subscribers who are eligible and participate in the opt-out program will receive **$1,500.00 per plan year** for an individual plan or **$2,500.00 per plan year** for a family plan, if they no longer take health insurance through the Town.

To qualify for this program, you must meet **BOTH** of the following requirements.

1. Currently be enrolled in a health insurance plan through the Town of Berkley for at least two consecutive years immediately preceding the requested date of cancellation.

2. Maintain credible health insurance coverage through a plan not offered by the Town of Berkley.

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Health Insurance Opt-Out Application

I hereby elect a monetary allowance in lieu of a Town of Berkley sponsored group health insurance plan. The amount of payment will be based upon the cancellation date of my current group health insurance plan with the Town of Berkley. *For example, a participant who cancels their insurance for July 1 will be eligible for 100% of the opt.–.*

_____ I understand that payments are to be made quarterly in the first pay period of September, December, March, and June. Each payment will constitute a fourth (1/4) of the stipend total and will not be prorated in the event of enrollment changes.

_____ 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 Berkley is not responsible for any expenses incurred after my insurance termination date for my dependents or myself.

_____ I certify that I have credible health insurance for me and or my dependents from a plan sponsor other than the Town of Berkley.

_____ I certify that there is no outstanding 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 **June 30, 2027,** and that I will need to re-apply yearly in order to continue in the program.

_____ I hereby acknowledge that I have been advised of my right to enroll in health insurance coverage through the Town of Berkley. 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 effective on the date listed.

Employee Signature:_____ Date:_____

Employer Signature:_____ Date Received:_____