

PAYMENT IN LIEU OF INSURANCE WAIVER AND RELEASE

CITY OF TRAVERSE CITY

I understand that under the City of Traverse City's Section 125 Plan, and under the City's Plan Document, regular employees eligible for the City's health insurance coverage can choose to receive a payment in lieu of health insurance if they have health insurance coverage through another source. The payment in lieu of health insurance amount will be \$200.00/month prorated or \$2400.00/year. Payment will be made in a lump sum with the last payroll of the fiscal year for which the insurance is waived. Documentation may be requested to demonstrate that I have health insurance coverage through another source.

I am presently covered under another health insurance program/plan. By signing below, I choose to waive my enrollment in the group health coverage offered by the City of Traverse City. I agree that my health insurance benefits through the City of Traverse City will be terminated as of July 1, _____.

I understand and agree this decision cannot be rescinded unless:

- I lose my group coverage elsewhere during this fiscal year, or
- I choose insurance during the next annual reopening period.

To rescind this decision, I must submit my intentions in writing to the City Human Resources Department.

If I do lose my coverage midyear and choose to enroll in the City's plan, I agree that my incentive payment will be prorated. I agree to notify the City if I lose my coverage through another source at anytime. I further understand that if I lose my coverage through another source, I must re-enroll in the City's plan within thirty (30) days from the date of losing coverage from another source. I understand that if I fail to re-enroll in the City's plan within thirty (30) days of losing coverage through another source, I will have to wait until the City's health insurance annual re-opener to re-enroll. If I lose coverage through another source and fail to re-enroll with the City's plan, I understand and agree that I will be fully liable and responsible for any and all healthcare-related claims, costs, fees, and charges arising during the time period and while I am without health insurance coverage.

I further release the City of Traverse City and each and all of its elected and appointed officials, employees, representatives, and agents from all liability, loss, costs, claims or damages whatsoever, in connection with the processing and handling of this authorization and from any healthcare-related claims, costs, fees, and charges whatsoever arising during the time period and while I am not enrolled in the City's plan.

By signing this document, I am acknowledging that I have read it and agree to all of its terms and provisions.

Printed Name

Signature

Social Security Number (last 4 digits)

Date