W A I V E R

HEALTH and/or DENTAL COVERAGE

This form is to be completed by all City of Milwaukee employees who do not elect the City of Milwaukee health insurance benefits.

I,_____, the undersigned, understand that I am eligible for a
(print last name, first name)
qualified health plan, according to the Affordable Care Act, through the City of Milwaukee. I understand I am eligible for dental benefits. By execution of this waiver form, I hereby waive my rights to health and/or dental coverage by checking the appropriate box below, signing and dating this form. I understand that if I should want such coverage in the future, I may be required to wait until the next open enrollment period to enroll *(if there is not a qualifying event).*

I further understand that if I do not have other health insurance benefits or coverage through a spouse or family member, I will be subject to the Affordable Care Act, and any financial penalties associated with not having health insurance benefits.

I understand that this waiver does **not** affect my eligibility for health or dental insurance benefits as a result of my obtaining coverage as the dependent of another City employee under a City of Milwaukee health or dental plan.

If you have any questions about this form, contact Employee Benefits Division (EBD) at 286-3184.

Please check 1 of 3

___ I elect to waive **only** my health coverage.

___ I elect to waive **only** my dental coverage.

___ I elect to waive **both** my health and dental coverage.

REASON FOR HEALTH WAIVER (please check 1 of 3)

___ 1 Married to other City employee
Spouse or Parent Name: _____ Emplid:_____
___ 2 Refused Coverage
___ 3 Other Coverage

EMPLID *(6 digit)*:_____ Dept/Div: _____

CANCEL EFFECTIVE DATE (1st of Month only) _____

EMPLOYEE SIGNATURE:_____DATE SIGNED:_____

NOTE: *Return this form to Employee Benefits Division, Room 701, City Hall* *Updated 9.12.16*