WAIVER

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 <u>not</u> 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 <u>only</u> 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