Health Insurance Opt-Out Financial Incentive Plan
City of Duluth, Georgia

Employee's Name (PRINTED): ____ SSN: ____________________

The City of Duluth offers a financial incentive for employees to elect not to cover themselves, their spouse, and/or eligible dependents through the City of Duluth's Health Insurance Plans, and who can obtain insurance through another employer, such as their spouse's employer. The decision to opt-out of the City's health insurance plans should be weighed very carefully by the employee.

Covered Member(s) who is/are opting-out:

PRINTED Name	SSN	Relationship to Employee
______________________________________	__________________	_________________________
______________________________________	__________________	_________________________
______________________________________	__________________	_________________________
______________________________________	__________________	_________________________

I fully understand and certify the following:

1. To be eligible to opt-out of the City-sponsored Health Insurance Plans, I and any covered dependents listed above, must maintain coverage under another comprehensive employer-sponsored group medical benefit plan. Medicare or insurance plans under the Affordable Care Act purchased in the Marketplace, are not considered employer-sponsored plans and are NOT eligible for any benefits under this policy.

2. The election to opt-out of the Health insurance plan is entirely voluntary. The City of Duluth is not responsible for any expenses incurred after my insurance termination date for myself or my covered dependents. Furthermore, I understand that my spouse, covered dependents and I are not eligible for COBRA continuation coverage through the City of Duluth's insurance once they have been removed from City coverage.

3. Elections to opt-out of the health insurance benefit plan must be made effective on the first day of the month following receipt of form and backup documentation. New hires are eligible on the first of the month following 30 days of employment if they have turned in the form and backup documentation.

4. If I opt-out, I am entitled to receive a flat dollar amount of $250 per month for removing myself from coverage, or $250 per month to remove my spouse from coverage, or $375 per month for removing both myself and my spouse from coverage, or $375 for removing myself and child(ren) from coverage, or $425 per month for removing my entire family from coverage. I understand that I can only receive one of these monthly amounts of incentive payment regardless of the manner or timing in which I may remove multiple members from coverage. (Children must be eligible dependents under age 26. Spouses must still be married in order to be eligible.)

5. I understand that I will only receive the financial incentive for months the City does not have to otherwise pay for coverage for me, my spouse, or my child(ren). If both spouses are employed by the City of Duluth, only one of them can received the opt-out payment.

6. I understand that I will not receive the financial incentive until acceptable documentation has been received to verify the alternative insurance coverage. Payments will not be backdated.

7. If I elect to opt-out, I can continue to be enrolled in the City-paid basic life insurance with AD&D, short-term disability, and long-term disability plans. I understand that I remain eligible to participate in the supplemental life insurance plans, dental plans, and other City-sponsored insurance plans which include employee and dependent coverage options. I further understand that I will remain eligible to participate in any voluntary insurance or other benefit plans which provide for payroll deduction of premiums or contributions.

8. If, at a later date, I or my dependents wish to re-enroll as a member of the City's health plan, I understand that my incentive pay will be appropriately modified to reflect the change of re-enrolling participants. I understand that I can only re-enroll at an open enrollment period, or when a "qualifying event" occurs as provided by in the Section 125 IRS rules and regulations.

9. I agree to return to the City all payments made in error, or for fraudulent acts which include, but are not limited to: (a) failure to report change and/or qualifying Changes in Status timely; (b) falsifying information in order to receive opt-out incentive payments.

10. I understand that if I, or any other listed members of my family become ineligible for the financial incentive due to the loss of other coverage, I must re-enroll in the City's health insurance plan within 30 days of loss of coverage or I will have to wait until the next open enrollment period.

11. I understand that any incentive payments made under this plan are included in an employee's routine payroll compensation and are taxable income. I also understand that any payments to an employee for this insurance incentive payment to carry medical Insurance with another company is **excluded** from calculations for the purpose of computing future retirement benefits under any defined benefit (pension) plan.

12. I understand that the City of Duluth reserves the right to modify or eliminate this incentive pay program at any time in its sole discretion. **Payments for the insurance incentive program are provided by monthly payments based on an annually adopted budget without any guarantee of future budget funding.**

13. I certify that I and other members of my family listed at the top of this form are covered under another comprehensive employer-sponsored group medical benefit plan and I wish to opt-out from the City of Duluth's sponsored Medical Insurance Plans for these named individuals.

14. I further state that I have read this form in its entirety and have seriously considered each of these provisions, that I have had the opportunity to ask any questions that have occurred to me, and I hereby submit this form relinquishing the medical insurance coverage available by the City of Duluth on the parties listed above in order to be compensated as described above.

15. I further assume all risks of financial detriment with respect to my election to opt out of the City-sponsored Health Insurance Plans. Further, I expressly waive any and all claims that I have or may in the future have against the City of Duluth, its officials, officers, agents, successors or assigns, due to my election to opt out of the City-sponsored Health Insurance Plans.

Employee's Signature: ____ Date: _______________

Name/Description of alternative insurance coverage:

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Date HR Received the Form: ___________________ Received By: _________________________ Rev. 9/27/2022