

CITY OF WAYLAND
Health Insurance Plan – Part 3

CASH OPTION/WAIVER OF HEALTH CARE COVERAGE

Employee Name: _____

I have been given the opportunity to received health care coverage under the City's health care program. I understand that by signing this form, and returning it to the City Manager's office, I am making a binding election to waive health care coverage for this plan year, and to receive a cash payment. On April 4, 2011 at the City Council Meeting, the Council voted to cap the City's medical insurance opt-out program to 50% of the Priority Health premium for Plan Year 2010-2011.

26 Payments will be added to your pay check during the plan year. No lump sums in advance payments are available. **Plan Year begins May 1st**

Option 1 - Family Opt Out is 50% of the 2010-11 Priority Health Family premium rate. The Family premium is \$721.12 per month = (\$8,653.44/annually). 50% opt-out rate is \$4,326.72/annually, \$166.42 per pay period. (Based on 26 pay cycles)

Option 2 - Double Opt Out is 50% of the 2010-11 Priority Health Double Employee premium rate. The Double premium is \$576.90 per month = (\$6,922.80/Annually). 50% opt-out rate is \$3,461.49/annually, \$133.13 per pay period. (Based on 26 pay cycles)

Option 3 - Single Opt Out is 50% of the 2010-11 Priority Health Single Employee premium rate. The Single premium is \$262.24 per month = (\$3,146.88/Annually). 50% opt-out rate is \$1,573.44/annually = \$60.52 per pay period. (Based on 26 pay cycles)

I understand that by signing this form, and returning it to the City, I am making a binding selection of my health care benefits for the next plan year. Questions concerning this benefit should be directed to the City Manager, or City Clerk's office.

Date: _____

Employee: _____

Date: _____

Manager: _____

Date: _____

Labor Rep: _____

Approved for Option: _____

Signed copies of this document shall be given to Payroll Dept. and City Clerk's office.

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