2027 Health and Vision Insurance Waiver

Employee Name:_____Department :_____

I certify that I have read, understand and agree to comply with the Waiver Incentive Program provisions as outlined in the Employee Handbook: Section 7.12 Insurance Opt-Out Incentive. I agree to reimburse the City a pro-rated amount of the waiver incentive payment that I received for the Plan Year 2027, effective with the date of re-enrollment in a City health plan or separation date of employment, and hereby authorize the City to make the appropriate payroll deduction.

I further certify that:

- ❑ I have health insurance coverage through another health insurance carrier, and waive my right to coverage under the City of Crest Hill's group health insurance plan, January 1, 2027 through December 31, 2027. I understand that if I waive my right to health insurance coverage through the City of Crest Hill, I can only re-enroll in the City's plans during the open enrollment period or if my eligibility or coverage in my current health insurance plan ceases.

By signing this document and providing the relevant insurance information as requested below, I will receive a payment for the waiver of health insurance for the plan year January 1, 2027 – December 31, 2027, based upon the level of eligible insurance waived, that will be spread over my bi-weekly paychecks.

_____ _____
Employee's Signature Date

_____ _____
Human Resources Director Date

_____ _____
City Administrator Date

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Please complete the following for your current health insurance coverage.

Insurance Carrier Name: _____Policy No: _____

Insurance Carrier Address: _____

_____

Name of Insured: _____Effective Date: _____

Employer Name Where Insured Has Coverage: _____

Person who can verify coverage: _____ Phone Number: _____

ATTACH A COPY OF YOUR HEALTH INSURANCE CARD OR LETTER VERIFYING COVERAGE, IF APPLICABLE, TO THIS FORM AND RETURN TO THE HUMAN RESOURCES OFFICE.