



**OFFICE OF THE  
TOWN ADMINISTRATOR**

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**Voluntary Waiver of Health Insurance**

**For Enrollment in Opt-Out Program**

I, \_\_\_\_\_, am an active employee for the Town of Grafton ("Town") and was covered by Town's health insurance eligibility criteria that are noted # 1 and #2 of the Health Insurance Opt-Out Policy. I hereby acknowledge that I have been advised of my right to enroll in health insurance coverage through the Town of Grafton. Having been so advised, I do hereby waive my right to health insurance coverage through the Town and I authorize the Town to cancel my existing health insurance coverage as of:

Date of Voluntary cancellation: \_\_\_\_\_

In return for my agreement to waive health insurance coverage, the Town agrees to pay me on a monthly basis for a total annual payment of one thousand dollars (\$1,000.00) for waiving my individual health insurance plan or two thousand (\$2,000.00) for waiving my family health insurance plan, whichever applies pursuant to the Town's Health Insurance Opt-Out Policy

I acknowledge that the Town of Grafton is not responsible for any expenses incurred after my insurance termination date for my dependents or myself. Furthermore, my covered dependents and I are not eligible for COBRA continuation coverage.

I understand that the Town of Grafton is not responsible for my medical coverage after my termination date (except for medical coverage for injuries and illnesses covered by M.G.L. c. 41, § III F or M.G.L. c. 152) and for each fiscal year thereafter that I voluntarily agree to waive health insurance coverage through the Town.

I certify that insurance coverage is in force elsewhere for losses in regard to medical conditions for me and my dependents, if any. Additionally, I have completed and submitted the Commonwealth of Massachusetts Employee Health Insurance Responsibility Disclosure (HIRD) Form.

NAME OF INSURANCE CARRIER \_\_\_\_\_

GROUP NUMBER \_\_\_\_\_

NAME OF POLICY HOLDER \_\_\_\_\_

TYPE OF COVERAGE \_\_\_\_\_

I hereby certify that there is no outstanding court order or agreement requiring me to provide health insurance coverage for my spouse, ex-spouse or dependent children, if any.

I hereby acknowledge that I am only eligible to re-enroll in the Town's health insurance plans during the Annual Open Enrollment Period or for a qualifying event. The qualifying events are:

- Marriage or divorce
- Birth or adoption of a child
- Death of a family member
- Lack of other coverage through no fault of the employee or subscriber
- Change in hours, which results in change of employment status

To reenroll, I must complete the required paperwork during the Open Enrollment period or, for a qualifying event, notify the Town Personnel Department and complete the re-enrollment process within thirty (30) days of the date of loss of coverage.

The GIC determines the effective date of when an employee will be terminated from benefits. This will coincide with the effective date of the opt-out payment to the employee.

I acknowledge that if I do re-enroll in the Town's group health insurance, if my employment with the Town ends, or if my hours are reduced to below 20 hours per week during the fiscal year, I will only be entitled to payment up to the month containing the date of the employee's separation, re-enrollment or reduction of hours below 20 hours per week.

I acknowledge that I may not participate in this plan by switching coverage to a spouse or parent, if they are also an employee of the Town of Grafton or the Grafton School Department.

I acknowledge that I have read, understand and agree to comply with the terms and conditions of the Town of Grafton's Opt-Out Policy.

Employee name/Employee signature

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Date