# REQUEST TO DECLINE AND WAIVE MEDICAL HEALTH INSURANCE COVERAGE

## (Medical Buy-Out) - 2019 Enrollment Form

I,_____, as a benefits eligible employee, have been offered enrollment in **County of Orange** sponsored health benefits that meet the Affordable Care Act requirements of both affordability and minimum value standards. However, I hereby request to decline and waive my enrollment in **County of Orange** sponsored medical health insurance for the 2019 Plan Year (Jan. 1 – Dec. 31, 2019).

I understand that during the Plan Year 2019, I must be continuously covered by another **employer based** medical health insurance plan. I am requesting enrollment in the **2019 Orange County Medical Buyout**, subject to the rules and regulations of the plan.

Accordingly, I hereby certify that I will have coverage under the following medical health insurance plan for 2019:

**Name of Health Insurance Plan for 2019:** _____

**This Coverage Belongs to:** (Name of Plan Holder/Relationship) _____

**Source of Coverage:** (Employer Plan Name) _____

**Last 4 digits of your Social Security Number : xxx-xx_____**

**Last 4 digits of the Plan Holder's Social Security Number : xxx-xx_____**

**Will all of your dependents, if any, have coverage under the above Plan? Yes____ No____**

**Is your spouse employed by Orange County Government or O.C.C.C. : Yes____ No____**

In making this request for 2019, I understand and agree that I and/or my dependents will not be eligible for **County of Orange** provided medical health insurance coverage for which I and/or my dependents would otherwise be eligible. Notwithstanding anything to the contrary in this form, I understand and agree that if I suffer an involuntary loss of this alternate coverage, I may apply to enroll in **County of Orange** medical health insurance coverage.

I understand and agree that my **Request to Decline and Waive Medical Health Insurance Coverage** shall remain in effect throughout the 2019 calendar year unless I suffer an involuntary loss of alternate coverage. In order to enroll in the medical health insurance coverage provided by the **County of Orange**, I understand that I must complete and submit to the Office of Risk Management a "Request to Resume Medical Health Insurance Coverage" and provide proof of the involuntary loss of coverage along with **a completed Change of Circumstance form**. The effective date of my medical health insurance coverage shall be subject to and conditioned on the requirements of the Employer's medical health insurance carrier(s) and the Office of Risk Management.

**Employee Signature** _____ **Date:** _____

**Print Name**_____

APPROVED BY Risk Management: Yes _____ No _____ Date_____

**Risk Management 255-275 Main Street Goshen NY 10924 845/615-3600**

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