REQUEST TO DECLINE AND WAIVE MEDICAL HEALTH INSURANCE COVERAGE

(Medical Buy-Out) - 2009 Enrollment Form

1. I,_____, as an active benefits eligible employee, hereby request to decline and waive my Employer sponsored medical health insurance for the 2009 Plan Year (Jan. 1 – Dec. 31) I understand that, during Plan Year 2009, I must be continuously covered by another medical health insurance plan to be eligible for waiver of Employer sponsored medical health insurance coverage. Accordingly, I hereby certify that I will have coverage under the following medical health insurance plan for 2009:

Name of Health Insurance Plan for 2009: _____

This Coverage Belongs to: (Name of Enrollee) _____

Source of Coverage: (Employer Name) _____

Your S. S. # :_____-_____-_____ **Your spouse's S. S. # :** _____-_____-_____

Your spouse's Name:_____

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

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

2. In making this request for 2009, I understand and agree that I and/or my dependents will not be eligible for Employer 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 re-establish Employer provided medical health insurance coverage, as described in Item. 4, explained below. I hereby acknowledge that I must complete and submit this waiver form to the Human Resource Office, during the annual open enrollment period, for each year I want to waive medical health insurance coverage**. In the event that I do not submit a new form (for continuation of the medical health insurance buy-out) to the Office of Risk Management during the next open enrollment period, I shall automatically be enrolled in the Empire Plan, unless contractually prohibited, effective January 1st of the following calendar year.**

3. I understand and agree that I will be compensated by the Employer for my waiver of medical health insurance coverage in accordance with the terms of the applicable collective bargaining agreement.

4. I understand and agree that my waiver of medical health insurance coverage shall remain in effect throughout the 2009 calendar year unless I suffer an involuntary loss of alternate coverage. In order to re-establish the medical health insurance coverage provided by the Employer, I understand that I must complete and submit to the Human Resource Office a "Request to Resume Medical Health Insurance Coverage" and provide proof of the involuntary loss of coverage. The effective date of re-establishment 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 Human Resource Office. In addition, I understand that these requirements may be changed at any time. If I submit the form "Request to Resume Medical Health Insurance Coverage" to the Human Resource Office, and my request is granted, I agree to forfeit the buy-out payment due me for the quarter in which I resume medical health insurance coverage, and thereafter.

Employee Signature _____ **Date:** _____

Print Name_____

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APPROVED BY Human Resources: Yes _____ No _____ Date:_____ 9/08