APPENDIX F

HEALTH BENEFIT OPT-OUT FORM

Employee Name_____ Date of Form Completion_____

Department_____ Effective Date of Cancellation_____

Statement of Election to Participate in Town of East Hartford Health Benefit Opt-Out Program

I elect to cancel my health insurance (but not my dental insurance) with the Town of East Hartford. The health plan that I will be covered under is offered through_____(name of company offering program). The name of the plan providing my insurance coverage is_____(name of health insurance carrier). This plan covers: _____my spouse _____my family and _____myself ***(check all that apply)***. Attached is documentation of my enrollment in the above plan.

In exchange for canceling my health insurance, I elect to receive a cash payment (totaling $1,000 for individual employee coverage, $1,250 for employee plus one dependent coverage or $1,500 for employee plus family coverage) to be paid in quarterly installments in October, January, April and July. I understand that by accepting the opt-out program, I am no longer covered by the Town's health insurance program. However, I will continue to be covered by the Town's dental insurance program.

_____ _____
Employee Signature Date

_____ _____
Witness Date