TOWN OF MILTON

MASSACHUSETTS

Health Insurance Opt-Out Application

The Town of Milton will continue to offer a health insurance opt-out program for all eligible subscribers enrolled in the Town's health insurance. **Please read this form carefully**. It is important that you understand all of the terms and conditions before submitting an application.

Subscribers who are eligible and participate in the opt-out program will receive **$2,500.00 per plan year** for an individual plan or **$5,000.00 per plan year** for a family plan, if they no longer take health insurance through the Town.

To qualify for this program, you must meet **BOTH** of the following requirements.
(Current enrollees in this Opt-Out plan will automatically stay enrolled)

1. Currently be enrolled in a health insurance plan through the Town of Milton for at least two consecutive years immediately preceding the requested date of cancellation.

2. Maintain credible health insurance coverage through a plan not offered by the town of Milton.

I hereby elect a monetary allowance in lieu of a Town of Milton sponsored group health insurance plan. I understand that the allowance will be paid in June of each year. The amount of payment will be based upon the cancellation date of my current group health insurance plan with the Town of Milton. *For example, a participant who cancels their insurance for July 1 will be eligible for 100% of the opt–out amount the following June.*

I understand that these payments may be considered income, may have tax implications and that I should consult a tax professional for more information.

I acknowledge that the Town of Milton is not responsible for any expenses incurred after my insurance termination date for my dependents or myself.

I certify that I have credible health insurance for me and or my dependents from a plan sponsor other than the Town of Milton.

I 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.

I understand that this program shall end **June 30, 2026,** and no allowances shall be paid for participating in this program after that date.

I hereby acknowledge that I have been advised of my right to enroll in health insurance coverage through the Town of Milton. 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 effective on the date listed.

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I understand that I may cancel this election and reenroll in a Town of Milton health insurance plan only:

- During annual enrollment periods
- After involuntary loss of my coverage through no fault of my own
- Through an accepted qualifying event
- If a change in family circumstances such as marriage, divorce, birth of a child, or end of spouse's employment.

Name (please print) Social Security #

Street Address

City State Zip Phone #

Signature Date

Town Department **Date of Hire** **Position**

Please circle your current plan

Health Insurance Provider	Harvard Pilgrim	Blue Cross Blue Shield
Type of Plan:	Individual	Family
Original Enrollment Date (must be prior to July 1, 2023)	_____	

Please return all applications to: HR, Town Hall, Select Board, 525 Canton Ave, Milton, MA 02186

DEADLINE: May 23, 2025, to OPT-OUT for July 1, 2025