HEALTH COVERAGE WAIVER FORM 2020-2021

Complete only if you do not want coverage under the City Health Plans

Printed Name:_____ Last four digits of SSN:_____

☐ I do not want to join the **City Dental Plan**

☐ I do not want to join to **City Medical Plan**

I certify that I have health care insurance coverage elsewhere. I waive my right to participate in the City of St. Louis Health Insurance Plan(s) for active employees that I have checked above.

I understand that if I choose to enter the Plan at a later date, I (and any of my dependents) may be eligible for health care insurance enrollment only during the two events listed:

1. **Annual Open Enrollment** - Held annually in the spring); and
2. **Special enrollment** – Applicable to an eligible employee who experiences a qualifying event and documents the event within 31 days of the date of the event. Examples of reportable events are: Commencement or dissolution of domestic partnership; birth, adoption or custody change of a child; death of the employee's spouse or dependents; a change in employment status; commencement or return from an unpaid leave of absence; loss or entitlement to Medicare or Medicaid; dependents aging out; eligibility or loss of eligibility of coverage under another health plan.

A qualifying event must be reported within 31 days of the date of the event along with proof of event document(s) in order for the change to be accepted.

I understand that the rules concerning future enrollment in the Plan and benefits payable under the Plan are discussed in detail in the Summary Plan Description document (SPD), and are subject to change in the future. I have received and reviewed a copy of the SPD.

I agree to release and discharge the City of St. Louis, its agents, employees, officers, directors, successors, affiliates, and subsidiaries, from any and all claims for payment, liabilities, demands and causes of action, known or unknown, fixed or contingent, on any theory whether legal or equitable, for medical treatment or services rendered after the date of this agreement or arising out of my voluntary decision to waive my rights to participate in the Plans.

_____ _____

Employee Signature | Telephone Date

City of Saint Louis Department of Personnel | Employee Benefits Section
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BenefitsSection@stlouis-mo.gov