# Livingston County
## 2027 WAIVER OF COVERAGE

**Employee Name:** _____

**Job Title:** _____

**Employee Number:** _____

**For the plan year effective 2027, I am waiving coverage for:**

☐ Myself ☐ Spouse ☐ Dependents(s) - If selecting dependent(s), please list their names:

_____

_____

**I am waiving coverage due to:**

☐ Coverage under my spouse's plan ☐ Other Coverage

_____

**This other coverage is:**

☐ Employer-sponsored Group Plan ☐ Individual Policy ☐ Medicare
☐ COBRA ☐ TRICARE ☐ Medicaid

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**Payment in Lieu of Health Insurance.** Full time employees who elect not to enroll in the group medical insurance plan because they are eligible for coverage under another qualified group health insurance plan available to their spouse and eligible dependents will be eligible to receive additional monthly compensation based upon their medical care coverage eligibility status. An employees' collective bargaining agreement or employment group will determine the amount of the opt-out payment. More information is available at www.livgov.com/hr.

Compensation in lieu of Health Insurance is not available to spouses who are both employed by the County.

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**Special Enrollment Notice and Certification –** *Please review and sign below if you wish to waive coverage.*

By signing below, I certify that I have been given an opportunity to apply for coverage for myself and my eligible dependents, if any. I am declining enrollment as indicated above. I understand, if I am declining enrollment for myself or my eligible dependents (including my spouse) because of other health insurance or group insurance health plan coverage, I may be able to enroll myself and my eligible dependents in this plan if I lose, or my eligible dependents lose, eligibility for that other coverage (or if the employer stops contributing towards my or my eligible dependents' other coverage).

I understand that I must request enrollment no more than 30 days after the date of the other health plan coverage ends (or after the employer stops contributing toward the other coverage). If I do not do so, I will not be able to enroll until my employer's next annual open enrollment period.

In addition, I understand that if I have a newly eligible dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself, and my eligible dependent(s). However, I must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

I understand that in order to request special enrollment or obtain more information, I should contact the Human Resources Department at (517) 540-8793 or Humanresources@livgov.com.

_____ _____ _____

Name of Employee Signature of Employee Date