

# MEDICAL & DENTAL INSURANCE BUY OUT ENROLLMENT FORM

I hereby elect, waive for heirs, my executors, administrators, and myself the following insurance coverage under the Village of Brockport group health plans:

Medical Insurance \_\_\_\_\_

Dental Insurance \_\_\_\_\_

I understand that I will receive the following payment from the Village of Brockport for each month that I decline coverage under the Village of Brockport policies.

<u>Coverage Eligibility</u>	<u>Medical</u>	<u>Dental</u>
Family Plan	\$416.67 (\$5,000 annually)	\$40 (\$480 annually)
Two Person Plan	\$287.33 (\$3,448 annually)	\$28 (\$336 annually)
Single Plan	\$169.00 (\$2,028 annually)	\$12 (\$144 annually)

I understand that I must re-enroll in this program annually, and that I cannot amend or discontinue my participation in the buy-out option during unless I have a change in family status or loss of, or significant change in alternate coverage.

I understand that I must maintain alternate insurance coverage in order to qualify for payment under the buy-out option. **Re-enrollment in the Village coverage may be denied or delayed if continuous coverage is not maintained.**

I have enrolled in the alternate insurance coverage as follows:

Medical: Carrier/Group: \_\_\_\_\_  
Company/Organization: \_\_\_\_\_  
Subscriber Name: \_\_\_\_\_  
Contract Number: \_\_\_\_\_

Dental: Carrier/Group: \_\_\_\_\_  
Company/Organization: \_\_\_\_\_  
Subscriber Name: \_\_\_\_\_  
Contract Number: \_\_\_\_\_

I release and hold harmless the Village of Brockport and its respective representatives, from and against any and all claims I may now have or in the future with respect to my election to participate in the BUY OUT Cash Option Plan.

I understand that neither the Village of Brockport, nor its respective representatives, shall be responsible or liable for any loss or expense which may arise or result from compliance with this election, nor shall they be responsible for any loss or expense which may result from the Village's refusal or failure to comply with this election.

\_\_\_\_\_  
Name (please print)

\_\_\_\_\_  
Name (please sign)

Date: \_\_\_\_\_