



**TOWN OF NEEDHAM**  
NORFOLK COUNTY MASSACHUSETTS

**Human Resources Department**

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## NOTICE OF NEW HEALTH INSURANCE OPT OUT PROGRAM

Beginning in FY2018, the Town of Needham will implement a Health Insurance Opt-Out Incentive Program. The program will allow eligible employees to opt out of their participation in the Town's health insurance program in return for a fixed payment. Program highlights and eligibility requirements are set forth below.

- Active employees who are currently enrolled and have been covered as the insured under the Town's health insurance program for twenty-four (24) consecutive months may opt-out of Town coverage.
- Employees choosing to opt-out of the Town's health insurance plan must sign and submit the Opt-Out Form provided by the Town, certifying that the insured and any eligible spouse and dependent(s) have enrolled in a health insurance plan elsewhere.
- Employees may enroll in the Opt-Out Incentive Program **at any time through the current sunset date of June 30, 2021** as long as they certify in writing that they will be receiving health insurance elsewhere as of the effective date specified. Employees may not retroactively opt-out of Town coverage.
- Employees who opt-out of Town coverage will be paid the amount of \$2,000 per full fiscal year for an individual plan and \$4,000 per full fiscal year for a family plan.
- The Incentive amount will be pro-rated if an employee opts-out or re-enrolls in the Town's health insurance program during the plan year.
- The Opt-Out Incentive will be paid via the employee's normal payroll cycle, less any required withholdings. The amount of the incentive payment will be divided equally over the plan year, which runs from July 1 to June 30. The Opt-Out Incentive payment will not be added to the base pay for employees, will not be used in the computation of overtime, and will not be subject to retirement withholding.
- Any employee who has opted-out of the Town's health insurance plan may re-enroll during the annual open-enrollment period, or within 30 days of a documented qualifying event, and the Opt-Out Incentive payment will cease.
- Employees who change from a family to an individual plan or vice versa will not be eligible for participation in this program. Employees who switch coverage to a spouse or parent who is also employed by or retired from the Town will not be eligible for participation in this program.
- The Opt-Out Incentive program will sunset on June 30, 2021 unless the Board of Selectmen votes to reauthorize the program.

If you have any questions or would like to enroll in the Opt-out Incentive Program, please contact Chuck Murphy-Romboletti, Assistant Director of Human Resources at x295 or [cmurphy-romboletti@needhamma.gov](mailto:cmurphy-romboletti@needhamma.gov).

**TOWN OF NEEDHAM  
EMPLOYEE HEALTH INSURANCE WAIVER FORM**

Please complete the following information. This form must be accompanied by the insurance plan's applicable disenrollment form, and a letter serving as proof of enrollment in alternative coverage on either the insurance company's or employer's letterhead, which must be received within 30 days from the effective date of coverage.

<b>Employee Name:</b>		<b>Department:</b>	
<b>Present Town-Sponsored Insurance</b>		<b>Alternative Insurance</b>	
Plan Name:		Primary Policy Holder:	
		Entity provided by:	
Coverage Type: <i>Family / Individual</i>		Insurance Carrier:	
		Plan Number:	
Date of Voluntary Termination:		Coverage Type:	
		Effective Date:	

I, \_\_\_\_\_, hereby elect an annual monetary allowance of \$2,000 for an individual plan / \$4,000 for a family plan in lieu of Town-sponsored group health benefits. I understand that this amount will be divided equally among and paid via my normal payroll cycle over the plan year. I also understand that this payment will be less any required withholdings, and will not be added to my base pay, not used in computation or subject to retirement withholdings.

I certify that insurance coverage is in force elsewhere as of the effective date above, for losses in regard to medical conditions for me and my dependents, if any.

I hereby acknowledge that I am only eligible to re-enroll in the Town's health insurance plans during the Annual Open Enrollment Period or for a qualifying event. To reenroll, I must complete the required paperwork during the Open Enrollment period or, for a qualifying event, notify my Human Resources Department and complete the re-enrollment process within thirty (30) days of the date of involuntary loss of coverage.

I understand all the terms of the Opt-out Program as stipulated in Board of Selectmen Policy PERS-003: Contributory Insurance Rules and Regulations.

**Employee Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

***Internal Use Only***

Director of Human Resources/designee signature: \_\_\_\_\_ Date: \_\_\_\_\_

- Insurance Company Disenrollment Form
- Original Enrollment Date: \_\_\_\_\_
- Amount Due for current FY: \_\_\_\_\_
- Payroll frequency: \_\_\_\_\_
- Proof of enrollment in alternative insurance