Amherst Pelham Health Claims Trust

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Amherst, MA 01002-2351

Phone: (413) 259-3123
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Health Insurance Opt-Out Election Form

Please carefully read each side and *PRINT CLEARLY*

Insured Name (First) (MI) (Last)

Street Address

City State Zip Code

APHCT Employer:

☐ Town of Amherst Municipal
☐ Amherst Elementary Schools
☐ Town of Pelham Municipal & School
☐ Amherst Pelham Regional Schools

Type of APHCT coverage: ☐ Individual ☐ Family

Name of APHCT health plan in which you are now enrolled:

☐ Blue Care Elect PPO

☐ Network Blue N.E. HMO

I understand that in order to participate in the opt-out program, I must be an active employee of one of the APHCT employers listed above and further understand that should my employment be terminated in any manner that my eligibility to participate in the program will terminate as well.

I understand that I must have had continuous coverage by an APHCT health insurance plan for at least one year immediately prior to the application for Opt-Out.

I hereby elect a monetary allowance in lieu of an APHCT sponsored group health insurance plan. I understand that the annual allowance is $1,500.00 for an individual plan and $3,000 for a family plan. The allowance will be paid in equal monthly installments while this election is in effect. The first monthly installment will begin in approximately 60 days from the date the Opt-Out application is approved. I understand that these payments will be treated as income and subject to appropriate withholdings.

I understand that I must maintain my basic life insurance.

My other non-APHCT health insurance coverage is not through a Federal or State sponsored program (such as the Health Connector or Mass Health). I have compared my other non-APHCT health insurance coverage with my APHCT coverage. The coverage is comparable and I can provide proof of coverage for myself and my dependents if they are currently enrolled in the APHCT health plan.

I understand that I may cancel this election (at which time payments will cease) and re-enroll in the APHCT plan only:

- during annual enrollment periods; or
- after involuntary loss of my other coverage through no fault of my own; or
- if a significant change occurs in other health insurance coverage other than premium cost; or
- if a change occurs in family circumstances such as marriage, divorce, birth of a child, or end of spouse's employment; or
- if my employment is terminated by my retirement.

I acknowledge that my decision to participate in the opt-out program is being made voluntarily and in no way affects my employment status.

Signature of Insured Date