DEPARTMENT OF HUMAN RESOURCES
CHIEF ADMINISTRATIVE OFFICE
CITY OF NEW HAVEN

200 Orange Street, New Haven, CT 06510
(203) 946-8252
(203) 946-7166 fax
www.newhavenct.gov

JUSTIN ELICKER
MAYOR

REGINA RUSH-KITTLE
CHIEF ADMINISTRATIVE OFFICER

Medical Benefits Waiver – Fiscal Year 23-24

For Eligible Local 884 Employees

(OPT-OUT Part A)

In accordance with Article 22, Section 1, of the current Local 884 Agreement, I (print name)_____ have chosen to waive (opt out of) the health insurance plans offered to me from July 1, 2023 through June 31, 2024.

I will receive a cash payment in lieu of health insurance coverage at the end of the fiscal year, as long as I am eligible, and I am not covered by a health insurance plan offered by the City of New Haven during the period noted above. (Payment for Fiscal Year 23-24 to be made in June 2024.)

I certify that all statements made in conjunction with this waiver are true, complete and correct to the best of my knowledge and belief and are made in good faith. I understand that incomplete, false or inaccurate information, regardless of when it is discovered, may result in forfeiture of payment under the Medical Benefits Waiver / Opt-Out Policy and may result in disciplinary action.

Signature_____ Date:_____

For June 2024 payment,
RETURN THIS FORM TO:
benefits@newhavenct.gov
Return by October 10, 2023

For HR / Med Benefit Use ONLY:

Emp# _____

D-O ☐ CODE _____ ☐

S ☐ C ☐ F ☐

Form not valid without both pages (Part A & Part B) completed – PLEASE COMPLETE BOTH SIDES OF PAGE

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Medical Benefits Waiver – Fiscal Year 23-24

For Eligible Local 884 Employees

(OPT-OUT Part B)

Employee Name: _____ Employee #:_____

Other Health Insurance: _____

You MUST attach proof of insurance coverage.

Insurance Proof Attached: *(describe)*_____

IMPORTANT: List persons who, if you *had* elected medical insurance coverage, would be included on your plan. The number of proven dependents affects the amount of your Opt-Out Payment for year 2023-2024. **You MUST attach related documents (marriage certificate, birth certificates, etc.) for proof of dependents.**

	NAME	Last 4 #s of Social Security #	Date of Birth
Self		xxx-xx-	
Spouse		xxx-xx-	
Dependent Child		xxx-xx-	
Dependent Child		xxx-xx-	
Dependent Child		xxx-xx-	
Dependent Child		xxx-xx-	
Dependent Child		xxx-xx-	
Dependent Child		xxx-xx-	
Dependent Child		xxx-xx-	

(list any additional dependents on additional paper if needed)

*Local 884 Agreement, Article 22:On an annual basis, employees who have alternate health insurance coverage may choose to waive the above listed health insurance and instead receive an additional lump sum payment in the amount of $1000 single / $1,500 w/Child / $2000 family. Employees who choose to exercise this waiver must so inform the Human Resource Department, in writing, by June 1 for the next year beginning July 1. Employees who have waived, but wish no longer to waive, shall inform the Human Resource Department, in writing, by June 1 for the next year beginning July 1. Waiver payments shall be disbursed on the first pay period following June 1 and only to those Employees still employed by the City on that date. Once a participant opts back into medical coverage or fails to exercise his/her right to continue opting out, he/she shall no longer be eligible. The waiver and payment shall terminate if not permitted by applicable law. Employees will be required to provide proof of insurance at the time of submission of the waiver and shall be prohibited from receiving any payment if covered by any other plan in the City or the Board or Education. *The 2023-2024 Medical Benefits Waiver due date was extended until October 10, 2023.**

Signature_____ Date:_____

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