

**ALLEGHENY COUNTY  
HEALTH CARE BONUS WAIVER OPTION ELECTION FORM  
CANCELLATION OF HEALTH CARE COVERAGE**

Plan Year Jan. 1, 2017 – Dec. 31, 2017

\_\_\_\_\_  
LAST NAME                      FIRST NAME                      M.I.                      PHONE NUMBER                      EMPLOYEE NUMBER

**The Health Care Bonus Waiver Option has been explained to me and I fully understand the terms and conditions of this Health Care Bonus Waiver Option.**

I, \_\_\_\_\_ decline coverage for myself and eligible dependents through The County of Allegheny group health plan for the Plan Year beginning on Jan. 1, 2017, and ending on Dec. 31, 2017

I understand that to receive payment under this Health Care Bonus Waiver Option, I must provide verification that I have health care coverage through another health care plan.

Unless stipulated by union contract, employees eligible for and/or receiving Allegheny County healthcare benefits by virtue of their relationship to another County employee shall not be eligible to participate in the Healthcare Bonus Waiver Program and will not receive payment for waiving benefits.

I further understand that I must cancel or waive both medical and dental coverage, if any, through Allegheny County to be eligible for this Health Care Bonus Waiver Option.

I also understand that I cannot revoke or change this election during the Plan Year unless I have a qualifying change in family and/or job status and that change is consistent with my change of election. I may then revoke my prior election and sign a new Agreement if a change in election event occurs.

Finally, I understand that to be eligible for the cash benefit component, other health insurance Minimum Essential Coverage cannot be individual coverage purchased on Healthcare.gov or a State Marketplace Exchange.

**I hereby waive my rights to all County-provided group health coverage available to me. If I want to continue to waive benefits, I must submit this form annually.**

\_\_\_\_\_  
Signature of Employee

\_\_\_\_\_  
Date

**TO BE COMPLETED BY COMPANY'S PERSONNEL/BENEFITS DEPARTMENT**

The above-noted individual is enrolled in the health plan provided by:

\_\_\_\_\_  
Company Name

\_\_\_\_\_  
Group Number

\_\_\_\_\_  
Effective Date of Coverage with this Company

**He/She is a dependent of our employee:**

\_\_\_\_\_  
Name of Individual Employed at our Company providing health care

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Signature of Company Official

\_\_\_\_\_  
Date

**CANCELLATION OF COVERAGE WITH ALLEGHENY COUNTY EFFECTIVE \_\_\_\_\_  
VERIFIED BY \_\_\_\_\_**