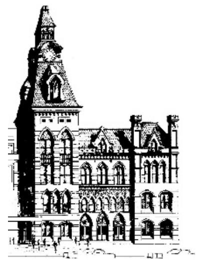
JUSTIN ELICKER
MAYOR

REGINA RUSH-KITTLE
CHIEF ADMINISTRATIVE OFFICER

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



Medical Benefits Waiver – Fiscal Year 24-25

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, 2024 through June 31, 2025.

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 24-25 to be made in June 2025.)

> 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 2025 payment,
RETURN THIS FORM TO:
AFuentes@newhavenct.gov
Return by June 1st 2024

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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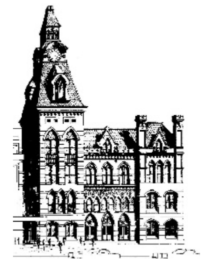

Medical Benefits Waiver – Fiscal Year 24-25

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 2024-2025. **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:__________

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

Anthem

Enrollment and Membership Change Form
Local 884 "Opt Out" Participants ONLY

DENTAL ONLY

1. Tell Us About You

Current Anthem BCBS Contract Number, if any

Last Name	First Name	M.I.

Home Address: Number and Street or P.O. Box	Apt.#

City	State	Zip Code

Home Telephone	Work Telephone

Marital Status
- ☐ Single ☐ Legally Separated ☐ Widowed
- ☐ Married ☐ Separated ☐ Divorced

Email address

2. Membership

☐ ENROLLMENT (add dep)

☐ CANCEL

Reason________________________

3. Change Membership

CHANGE:
- ☐ ADDRESS (indicate **NEW** address at left)
- ☐ NAME (Indicate **Former** Name below)

____

☐ OTHER REASON (Birth, Marriage, Divorce, Loss of Coverage Event etc.)

____

____

EVENT DATE MM/ DD/ YY

To Be Completed By Employer

Requested Effective Date

MM/DD/YY

Firm Division No

Health Benefit Plan

DENTAL ONLY

For Office Use Only

Form revised 04/2020

4. Your Membership Choices – Local 933

	Individual	Two Person	Family	
☐ DENTAL	☐	☐	☐	950

Please note that this application is for participants of the Medical Benefits Opt Out Waiver who elect Dental ONLY. As an eligible member of Local 933 participating in the Medical Benefit Waiver Opt Out program, you may elect Dental coverage for yourself and your family while remaining in the Opt Out program.

5. Where You Work

Department/Division Name

BOARD OF EDUCATION, LOCAL 933 TEACHERS

Only complete and return this form if you are keeping, adding, changing, or cancelling Dental coverage AND you are a current participant in the Medical Benefit Opt Out program.

DATE OF FULL TIME HIRE

6. List Members to be included on Dental

Gender	Name (First/Middle/Last)	Add	Cancel	Social Security Number	Date of birth (MM/DD/YY)	
☐M ☐F	Self					
☐M ☐F	Spouse					
☐M ☐F	Dependent					
☐M ☐F	Dependent					
☐M ☐F	Dependent					
☐M ☐F	Dependent					

7. Tell Us About Your Other Insurance

Do you or any other member of your family have any other medical, dental, or Anthem BCBS coverage?
If yes, please fill in the information below ☐ Self ☐ Spouse ☐ Children

Name of Other Insurance Company	Name of Subscriber (Policy Holder)	Policy or ID No.	Reasons For Termination	First and Last Date of Coverage

8. Medicare/Medicaid

Do you or any covered member have Medicare/Medicaid coverage? ☐ YES ☐ NO

Have you or any covered member applied for Medicare/Medicaid disability? ☐ YES ☐ NO

Name (self)	Are you actively at work? ☐ YES ☐ NO	Retired Date MM/DD/YY	Name (Dependent)	Is this person actively at work? ☐ YES ☐ NO	Retirement Date MM/DD/YY

Medicare No. — **EFFECTIVE DATES** Medicare A (Hospital) MM/DD/YY, Medicare B (Medical) MM/DD/YY

Medicare No. — **EFFECTIVE DATES** Medicare A (Hospital), Medicare B (Medical)

I understand that false and or incomplete responses or statements may result in rescission of coverage and/or non-payment of claims for myself or my eligible dependents. I understand a copy of this application is provided to me as part of my Subscriber Agreement or health benefit plan document as applicable and is incorporated by reference therein. I certify that my statements in this form are true and complete to the best of my knowledge and belief.

9. Employee Signature

Date MM / DD / YY

If you enroll in these group dental benefits available to you as an employee of the City of New Haven, your share of premiums will be deducted from your pay tax-free. However, participation is voluntary.

INSTRUCTIONS

Please print all information

THANK YOU FOR CHOOSING OUR PLAN

How to Fill out This Form – Press Firmly – Please Use Ballpoint Pen

Please read the instructions before filling out he attached Enrollment and Membership Change Form. Here's what you need to fill out, so we can enroll you without delay.

For membership changes, complete:
Section 1. "Tell Us About You"
Section 3. "Change Membership"
In addition, when adding/canceling eligible dependents, or changing a primary care physician (PCP), complete:
Section 6. "List Family Members"

1. Tell Us About You

Please complete all information in this section.

2. New Membership

Please check the appropriate box.

REASON CODE	QUALIFYING EVENT	REASON CODE	QUALIFYING EVENT
01	Divorce	04	Dependent child no longer eligible under terms of employer's contract
02	Termination of employment	05	Reduction in hours/no longer meet group eligibility requirements
03	Spouse of deceased employee		

3. Change Membership

Please check the appropriate box if you are changing membership. Please indicate the reason and date. Some examples include:

ADDRESS	MARRIED	DEPENDENT
PCP	LEGALLY SEPARATED	BIRTH
NAME	DIVORCE	ADOPTION

4. Your Membership Choices

A. Tell us the plan name in which you are enrolling. To do this, check the appropriate box next to your selection choice.
B. Please Check Individual, two person, or family.

5. Where You Work

Please complete all information in this section

6. List Members to Be Added/Cancelled

A. Please be sure to complete all information in this section including social security numbers and date of birth.
B. Indicate Last name if different.

7. Tell Us About Your Other Insurance

Please be sure to note any other insurance information in this section

8. Medicare/Medicaid

Please complete all information in this section if you or an enrolled member is covered by Medicare or Medicaid, or have applied for Medicare/Medicaid disability.

9. Employee Signature

Please sign and return the completed application to your benefits coordinator. Save a copy of this form for your records until you receive you identification card(s). A copy of this application is provided to you as part of your Subscriber Agreement or health benefit plan document as applicable and is incorporated by reference therein.