City of Marietta, Georgia
Flexible Spending Medical Arrangement **2018**

ELECTION FORM FOR: HEALTH BENEFIT WAIVER OPTION AGREEMENT

PLEASE PRINT

NAME:_____

FIRST **MI** **LAST**

EMPLOYEE NO:_____ **DEPT:** _____

ADDRESS: _____

CITY:_____ **STATE:**_____ **ZIP:**_____

ELECTION OF MEDICAL REIMBURSEMENT ACCOUNT UNDER THE HEALTH BENEFIT WAIVER OPTION

I ELECT TO ESTABLISH A MEDICAL REIMBURSEMENT ACCOUNT UNDER THE CITY OF MARIETTA'S HEALTH BENEFIT WAIVER OPTION

_____YES _____ NO

If "Yes", choose either Employee or Family coverage. This selection will determine the amount of money contributed on your behalf into the flexible spending arrangement (FSA) in your name. *This coverage option must match the proof of coverage, from a provider other than the City, on file with the City of Marietta.*

NOTE: This agreement waives COBRA medical insurance once separated from the City.

_____ EMPLOYEE (Please contribute $300 per year in my name into a medical reimbursement account.)

_____ FAMILY (Please contribute $500 per year in my name into a medical reimbursement account.)

*Must list all currently covered family members below.

If the Family Coverage Option is marked, please list all eligible dependents who qualify for coverage on the City of Marietta's health insurance plan as of the date of your signature on this form:

PLEASE PRINT (Must be filled out if Family Coverage Option is checked above.)

Employee:	Spouse:
Child:	Child:
Child:	Child:
Child:	Child:

I have read and understood all the Terms and Conditions of this Agreement on the reverse side of this document and verify the same by my signature.

_____

SIGNATURE DATE

TERMS AND CONDITIONS

Health Insurance Benefit Waiver - Terms and Conditions

If hired prior to November 1, 2006, the City of Marietta pays 100% of POS health insurance benefit premiums for employees and 80% for employees' covered family members' health insurance benefit premiums. If hired after November 1, 2006, the City/BLW will pay 85% of the single POS premium for employees and 80% for employees' covered family members' health insurance benefit premiums. By my signature, I am electing to waive this health insurance coverage for myself, as employee, and all my covered family members on record as of this date (if any), and choose, instead, the City of Marietta's contribution in my name of either $300 per year (single coverage) or $500 per year (family coverage) into a flexible spending arrangement (FSA) for medical benefits as described below.

In order to qualify for this option, I understand that I must comply with all requirements listed below: I must submit proof of insurance coverage under another health insurance plan, other than the City, for myself (and any family members eligible for coverage under the City's plan if selecting the family option) to the Benefits Manager or his/her designee before I am eligible to participate.

Acceptable proof of other insurance coverage will be limited to: (1) a letter, on company letterhead, from the employer and/or company listing all covered family members, date insurance was/is effective, and a statement verifying active coverage; or (2) a certification of insurance letter as required by HIPAA; or (3) an insurance card with a phone number to call in order verify coverage.

I must notify the Benefits Manager or his/her designee within thirty (30) days of any qualifying event which would affect this agreement. This includes loss of other insurance coverage, which would require both my family, if previously covered, and myself to re-enter the City of Marietta's health insurance program. The City will offer either the same health coverage as is currently being terminated by this agreement, or its equivalent.

Qualifying Event is defined by the IRS regulations as: (1) marriage or divorce of the employee; (2) death of the employee's spouse or dependent; (3) birth or adoption of the employee's child; (4) commencement or termination of employment of the employee's spouse; (5) a switch from part-time to full-time status, or vice versa, by the employee or the employee's spouse; (6) an unpaid leave of absence taken by the employee or the employee's spouse; and (7) a significant change in the health coverage of the employee or spouse attributable to the spouse's employment.

I understand that if I do not notify the City of Marietta Benefits Manager or his/her designee within 30 days of the date of loss of other insurance coverage, I will be required to wait to regain health insurance with the City of Marietta until the next open enrollment period. In all cases, proof of the date of loss of health insurance will be required.

After meeting all of the above qualifications, I understand that in lieu of receiving the City's health insurance benefit for myself or my covered family members (if any), the City of Marietta will contribute for me into a flexible spending arrangement (FSA) in my name the amount of $25.00 per month (employee-only coverage) or $41.67 per month (dependent(family)-coverage) to be used only for reimbursement of qualified medical expenses (as defined by IRS Code Section 213(d)) which are not paid for by the other insurance coverage.

Examples of reimbursable expenses include, but are not limited to co-pays for doctor visits and prescription drugs, birth control pills, chiropractor expenses, hearing aids, expenses over and above what health insurance will pay for dental work, eye exams, glasses/contact lenses and solutions. Note: Premiums for health insurance are specifically precluded as a reimbursable expense under this plan by the IRS. Visit www.tasconline.com about other qualified medical expenses.