



Putnam County Personnel Department
Retiree Health Insurance Waiver Form

YOU MUST MAKE THIS ONE-TIME CHOICE PRIOR TO RETIREMENT
NO LATER THAN YOUR LAST DAY WORKED
If you do not make a choice, you will receive no sick time benefit

Under the CSEA Contract you may elect to waive retiree health benefits and receive a financial benefit of 50% the value of the individual coverage with the most enrollees.

Please complete

Retiree Health Insurance Waiver Form- CSEA
Table with columns: Yes/No, Initial
I elect to waive Retiree Health coverage.
I understand that waiving retiree health insurance is a permanent choice.
I have alternative coverage and have attached proof of same.
Company _____ Policy Holder _____
Effective Date _____ Policy # _____
Authorization
I have read the information provided to me regarding Retiree Health Insurance and understand that once I waive Retiree Coverage I may not request to return to the plan as a retiree.
Employee Name _____ Employee Signature _____ Date _____
HBA Name _____ HBA Signature _____ Date _____

Pursuant to Article IX, Section A(2) of the Collective Bargaining Agreement between the County of Putnam and CSEA, I hereby declare my choice to decline continuation of coverage under the health insurance plan of Putnam County, and verify that I am currently covered under the plans/policies noted above. I understand that my Putnam County health insurance coverage will terminate effective first of the month following receipt of this waiver form. If I choose to re-enroll in the future, my enrollment will be subject to Plan rules regarding effective dates of coverage and documentation requirements. I agree to provide verification of my health insurance status annually.

Please make a copy of this signed waiver form for your records.