

CITY OF WAUPACA  
"OPT-OUT"  
MEDICAL PLAN WAIVER FORM

Please Print or Type

Company: \_\_\_\_\_ Department: \_\_\_\_\_

Employee Name: \_\_\_\_\_ SS#: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

I hereby elect not to participate in a Medical Plan beginning on \_\_\_\_\_. I am electing to receive medical insurance coverage under my spouse's employer's plan or another non-city group medical plan and I am providing the identifying information on the alternate medical plan below and have attached a copy of my medical plan identification card.

The incentive shall be a maximum amount of 3900.00 per calendar year. Employees may elect to have the opt-out funds deposited into Wisconsin Deferred Compensation biweekly and are subject to the rules governing the plan or added to their paycheck as taxable income biweekly.

I understand that I cannot change or revoke this agreement any date prior to the next plan year unless I have a significant change in family status as described in the enrollment materials.

I understand that every year during open enrollment, I have the option to re-apply for medical insurance or continue in the Opt-Out Benefit for the following Plan Year.

**COMPLETE IN FULL & ATTACH COPY OF MEDICAL ID CARD:**

Spouse's Name: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_

Alternate Medical Plan Administrator/  
Insurance Carrier: \_\_\_\_\_ Alternate Medical Plan Group #: \_\_\_\_\_

Employee's Signature: \_\_\_\_\_

Employer's Agent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

- I elect to have funds deposited in Wisconsin Deferred Compensation.
- I elect to have funds added to my paycheck.