TOWN OF RIVERHEAD
HEALTH INSURANCE BUY BACK FORM-NON UNION

STATE OF NEW YORK)
)ss
COUNTY OF SUFFOLK)

_____being duly sworn deposes and says:

1) I am a full-time employee of the Town of Riverhead.

2) That pursuant to Town policy, I am entitled to Health Insurance, and the Dental Care benefits through Delta Dental and Optical Care benefits through Eyemed Vision Care. However, the terms also provide that I may waive coverage by the Town for a payment for any single calendar year, payable to me in the month of December for the calendar year I waived my coverage. Provided I waive coverage subject to the terms on the attached form for the entire calendar year. I understand that no prorations will be given if I only want to waive coverage for part of the year and no payment will be made to me whatsoever for such waiver. I understand that I do not have to waive all three coverages and that I may select to waive one or any combination of the three coverages. I hereby request my coverage to be waived and hereby execute this form as proof that I fully understand that I am no longer covered by the TOWN OF RIVERHEAD for the coverage that I have waived per the attached form. Further, I understand that this waiver for health, dental or optical insurance will remain in effect until I elect to have my insurance reinstated, even though this may be for more than one calendar year.

3) That I understand that none of my doctor bills will be reimbursed through the plans and I must, therefore, look to other health insurance, dental or optical care coverage provided by myself or through my spouse.

4) This plan meets requirements of Affordability and Minimum Value. In waiving coverage, I understand that I and/or my dependents may re-enroll only during the open enrollment period, unless I or they have suffered a qualifying event. I understand the effective date for coverage elected during the open enrollment period is January 1 of each calendar year; I further understand that coverage elected due to a qualifying event is the date of the event.

5) That I fully understand the contents of this affidavit, make this affidavit of my own free will without any pressure from anyone to sign this document.

MUST BE RETURNED TO THE PERSONNEL DEPT. NO LATER THAN 2/28/25; NO LATE FORMS WILL BE ACCEPTED, NO EXCEPTIONS

2025

PLEASE CHECK THE FOLLOWING OPTIONS THAT PERTAIN TO YOU:

HOSPITALIZATION:

1) Buy back for Health Insurance family coverage _____= $1,650.00
Eligible for a family plan; waive all coverage

Reason for Waiving Coverage - Please Check One:
[ ] Covered through spouse's employer [ ] Covered through a parent's employer
[ ] Under 65 Retiree covered by previous employer's insurance program
[ ] Other Please specify: _____

2) Buy back for Health Insurance single coverage _____= $ 900.00
Eligible for a family plan; elect single coverage

3) Buy back for Health Insurance single coverage _____= $ 750.00
Eligible for a single plan; waive all coverage

Reason for Waiving Coverage - Please Check One:
[ ] Covered through spouse's employer [ ] Covered through a parent's employer
[ ] Under 65 Retiree covered by previous employer's insurance program
[ ] Other Please specify: _____

DENTAL:

1) Buy back for Dental Insurance family coverage _____= $ 230.00
Eligible for a family plan; waive all coverage

2) Buy back for Dental Insurance single coverage _____= $ 150.00
Eligible for a family plan; elects single coverage

3) Buy back for Dental Insurance single coverage _____= $ 80.00
Eligible for a single plan; waives all coverage

OPTICAL:

1) Buy back for Optical coverage _____= $ 25.00

TOTAL BUY BACK = $_____

Sworn to before me this

_____ day of _____, 20__.

_____
NOTARY PUBLIC

_____
Signature

_____
Signature

_____
Social Security Number

_____
Date