Town of Winchendon
Office of the Collector/Treasurer

109 Front Street
Winchendon, MA 01475

Telephone (978) 297-0152
Fax (978) 297-5409

Town of Winchendon Employee,

The Town of Winchendon is offering a health insurance opt-out program for all eligible subscribers enrolled in the Town's health insurance. Please read this form carefully. It is important that you understand all of the terms and conditions before submitting an application.

Subscribers who are eligible and participate in the opt-out program will receive **$1,500.00 per plan year** for an individual plan or **$3,000.00 per plan year** for a family plan if they no longer take health insurance through the Town.

To qualify for this program, you must meet the following requirements.

1. Currently be enrolled in a health insurance plan through the Town of Winchendon for at least one consecutive year immediately preceding the requested date of cancellation.

2. Retain credible health insurance coverage through a plan not offered by the town of Winchendon.

Please circle all applicable categories

Health Insurance Provider	Blue Cross Blue Shield	
Requested Effective Date:	July 1	
Type of Plan:	Individual	Family

Name (please print) Social Security #

Street Address

City State Zip Phone #

I hereby elect a monetary allowance in lieu of a Town of Winchendon sponsored group health insurance plan. I understand that the allowance will be paid in July of each fiscal year for the life of the existing Health Insurance Memorandum of Agreement (FY24, FY25, and FY26). The amount of payment will be prorated based upon the cancellation month of my current group health insurance plan with the Town of Winchendon. *For example, a participant who cancels their insurance for July 1 will be eligible for 100% of the opt–out amount. A participant who cancels their insurance January 1 will be eligible for 50% of the opt-out amount.*

I understand that these payments may be considered income, may have tax implications and that I should consult a tax professional for more information.

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I acknowledge that the Town of Winchendon is not responsible for any expenses incurred after my insurance termination date for my dependents or myself.

I certify that I have credible health insurance for me and or my dependents from a plan sponsor other than the Town of Winchendon, and proof of such insurance has been filed with the Treasurer's Office annually.

I certify that there is no outstanding court order or agreement requiring me to provide health insurance coverage for my spouse, ex-spouse or dependent children.

I understand that this program shall end **June 30, 2026** and no allowances shall be paid for participating in this program after that date unless agreed upon in a future Health Insurance MOA.

I hereby acknowledge that I have been advised of my right to enroll in health insurance coverage through the Town of Winchendon. Having been so advised, I do hereby waive my right to health insurance coverage through the Town and I authorize the Town to cancel my existing health insurance coverage effective on the date listed above.

I understand that I may cancel this election and reenroll in a Town of Winchendon health insurance plan only:

- During annual enrollment periods.
- After involuntary loss of my coverage through no fault of my own.
- Through an accepted qualifying event.
- If a change in family circumstances such as marriage, divorce, birth of a child, or end of spouse's employment.

_____

Signature Date

_____

Town Department Position

Please return all applications to the Office of the Treasurer, Town Hall, 109 Front Street, Winchendon, MA 01475

DEADLINE: Wednesday, June 1, 2023 (for July 1 cancellation)