ERIE COUNTY MEDICAL CENTER CORPORATION

HEALTH AND DENTAL INSURANCE WAIVER

NO ECMCC PROVIDED HEALTH INSURANCE FOR YOU OR FOR YOUR FAMILY MEMBERS WILL BE CONTINUED UNDER THE EFFECTIVE TERMS OF THIS WAIVER

I hereby for myself, my heirs, executors and administrators, waive my rights to ECMCC provided health and dental insurance coverage pursuant to the Collective Bargaining Agreement between the County of Erie and the :

1. ☐ Blue Collar Unit: AFSCME Council 66, Local 1095, AFL-CIO
2. ☐ White Collar Unit: Local #815, CSEA, Local 1000 AFSCME, AFL-CIO
3. ☐ New York State Nurse's Association (NYSNA)
4. ☐ No bargaining unit, Managerial/Confidential status

NOTE: To elect to waive health and dental insurance you must check the bargaining unit (above) to which you belong, or Managerial/Confidential status if you are exempt from bargaining unit status.

Employees in the AFSCME or CSEA bargaining units are not eligible for the waiver when they are covered by another ECMCC/County employee or retiree for health insurance. These employees are required to notify the Employer within 30 days of the occurrence of an event leading to this situation.

I understand the RISK inherent to electing the Health Insurance Waiver Option and assume any and all responsibilities for said RISK to myself, my heirs, executors and administrators.

I release any and all rights and claims I may have against ECMCC and/or the bargaining agent indicated above, and their respective representatives, as a result of my waiver of health and dental coverage to which I was previously entitled.

I understand that once this withdrawal of health insurance coverage is in effect, I may not re-enter any ECMCC provided insurance plan until the next annual Open Enrollment Period, unless I incur a "life qualifying event".

I have read the above waiver and upon my reading, fully understand its content.

Employee Name (Print) _____

WAIVING HEALTH ☐ YES ☐ NO ☐ FAMILY ☐ SINGLE

WAIVING DENTAL ☐ YES ☐ NO ☐ FAMILY ☐ SINGLE

WAIVER MUST BE SUBMITTED TO PERSONNEL DEPARTMENT BY THE 15th OF THE PREVIOUS MONTH OF EFFECTIVE DATE

Employee Signature _____ Date of Signature_____

Please complete the following information if you are applying for a family waiver - Supporting Documentation must be attached for family coverage (Example: Marriage License for spouse, Birth Certificates for children)

Name of Dependent	Social Security Number	Date of Birth

This section to be completed only by Department Personnel Representative

Employee Name: Emp. # Effective Date:

Bargaining Unit: Status: Hire Date: