City of Clearwater
Medical Insurance Waiver and Release
Plan Year 2016

I, the undersigned, hereby voluntarily enter into and agree to the following conditions in order to be permitted to waive my participation and that of any eligible dependents in any medical insurance plan option available to City of Clearwater employees for health insurance plan year 2016:

- I understand and agree my election to waive medical insurance coverage for myself and any eligible dependents under the City's plan is strictly voluntary on my part.
- I understand and agree the City will not provide compensation to me in any form as a condition of permitting my election to waive participation in the City's medical insurance plan.
- I understand and agree I am required to show proof of insurance prior to the beginning of the City benefit plan year, January 1, 2016. I further understand and agree that if I do not comply with this requirement, I will be required to voluntarily elect coverage in one of the City medical plan options or will be enrolled by the City in employee-only coverage in the medical insurance plan option for which the City pays 100% of the premium for benefit plan year 2016 if I fail to do so.
- I understand and agree that by electing to waive participation in the City's medical insurance plan I will be eligible to re-enroll in the City's medical insurance plan only if I experience a qualifying event during the plan year, or during the next open enrollment period.
- I understand and agree that by electing to waive participation in the City's medical insurance plan neither I nor any of my eligible dependents will be permitted to utilize the City's Employee Health Center.
- I affirm that I am currently under no obligation or settlement terms, legal or otherwise, to provide medical insurance coverage for any person who may legally be considered an eligible dependent.
- I hereby agree to protect, indemnify, and hold the City and its officers, employees and agents free and harmless from and against any and all losses, penalties, damages, settlements, costs, charges, professional fees or other expenses or liabilities of every kind and character arising directly or indirectly out of my election to waive participation for myself and any eligible dependents in the City's medical insurance plan.

Signed, _____

STATE OF FLORIDA)
COUNTY OF PINELLAS)

BEFORE ME personally appeared _____, who acknowledged executing the foregoing instrument. (S)he is personally known to me and did not take an oath.

WITNESS my hand and official seal this _____ day of _____, 2015.

_____

Print/Type Name: _____
Notary Public