

**Dunn County Health Insurance
Monthly Incentive Payment**

IRS Regulations require Dunn County receive evidence of alternative coverage every plan year in order for the employee to be eligible for opt-out arrangement (monthly incentive). If you wish to continue receiving a monthly incentive, you must complete this form and provide proof of coverage **annually**.

Eligible employees electing to not be covered by the County's family health insurance plan by deleting all coverage, and who prove that they, their spouse, and dependents have health insurance coverage from another source, shall be compensated by the County in the amount of \$900 per year which will be paid out over 26 pay periods. The employee may elect to have health insurance coverage reinstated, and payments curtailed, without evidence of insurability, during: (1) the annual open enrollment period or (2) whenever the employee undergoes a "qualifying life event" as defined below.

Eligible employees electing to take the County's single health insurance plan instead of a family plan, or reducing coverage from a County single plan to no health insurance plan, and who prove that they, their spouse and dependents have health insurance coverage from another source, shall be compensated by the County in the amount of \$600 per year which will be paid out over 26 pay periods. The employee may elect to have health insurance coverage reinstated, and payments curtailed, without evidence of insurability during: (1) the annual open enrollment period or (2) whenever the employee undergoes a "qualifying life event" as defined below.

Eligible employees opting to delete or reduce coverage under the above two paragraphs must inform the Employer in writing during the annual open enrollment period. Such deletion or reduction shall take effect on January 1st of the following year; with bi-weekly payment beginning in January of the following year.

Employees must notify the County within thirty (30) days after the qualifying event occurs.

Qualifying Life Events:

- a. Other coverage has been terminated or substantially reduced
- b. Legal separation
- c. Divorce
- d. Death
- e. Reduction in number of hours worked (full time to part time)
- f. Birth or adoption
- g. Marriage

CHECK 1 BOX:

- I elect to not be covered by the County's family health insurance plan. *
- I elect to not be covered by the County's single health insurance plan. *
- I elect to take the County's single health insurance plan instead of the family plan. *

*I have attached proof of health insurance coverage. It is my responsibility to notify the Employer if this coverage changes.

Employee Signature

Date

**Employees – Return this signed form to your payroll center.
Payroll Centers – Return signed form to the County Manager's office.**