CITY OF MAUMEE
2024 Health Care Change Form
Full-time Employee

Please print or type the following information:

Employee Name:	**Social Security #**	**Date of Birth:**	**Phone:**	**Email:**
Spouse Name:	**Social Security #**	**Date of Birth:**	**Phone:**	**Email:**

Circle One:	SIngle	Family		Reduced coverage (elect Single, eligible for Family		Waive
Name	**Relationship (Spouse, dependent child, or other dependent)**	**Primary Coverage Yes or No**	**Social Security #**	**Dependent Child 19-26? Yes or No**	**Date of Birth**	**Marriage date (Spouse only)**

☐ I hereby wish to change my health care coverage as noted above and authorize the necessary pre-tax payroll deduction. I understand the deductions will be made in the month prior to the month of coverage.

☐ If I have elected to waive coverage as noted above, I understand that the next open enrollment period will be for coverage to be effective January 1, 2025, through December 31, 2025.

☐ I agree to notify the City of Maumee of any change in status of any of my dependents or spouse which would render them ineligible for coverage under the terms of the City's insurance plan (i.e. *qualifying event* such as emancipation, marriage, divorce, employment change for spouse resulting in change of available insurance coverage, etc.) within fourteen (14) days of such occurrence. If such notification is not made, I understand that I will be responsible for refunding to the City of Maumee the amount of any premiums paid and / or benefits received under the City of Maumee health care plan for my dependent or spouse during the period in which the dependent or spouse was not eligible for coverage under the terms of the City's insurance plan. I further understand that if such timely notification is not made, I may also be subject to disciplinary action.

Employee Signature _____ Date _____