



Request for

Medical Insurance Waiver Cash Benefit Payment (HIW)

I affirm that I have opted out and are not a covered dependent of the Village of Park Forest's medical insurance coverage for the benefit year that runs from July 1, 2025 thru June 30, 2026.

I affirm that I have coverage under a spouse, parent, VA, or civil union partner's health insurance. Proof of this coverage (i.e. Copy of a valid medical insurance card) accompanies this Request. I request a cash benefit payment of \$2,000 in accordance with Village's Medical Insurance Opt-Out Cash Benefit. I acknowledge this payment will be issued in two (2) installments in accordance with other cash benefit payments issued by the Village.

Printed name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Return this form to Rachel Jones, HR Generalist

Date received: \_\_\_\_\_ by: \_\_\_\_\_

VILLAGE OF PARK FOREST  
INSURANCE COVERAGE DECLINATION FORM

Please complete this form **ONLY if you do not want coverage for yourself and/or your dependents.**

**Proof of coverage is required to accompany this form.**

<b>SECTION A: PERSONAL INFORMATION (to be completed by the employee- please print legibly)</b>	
Last Name: _____	First Name: _____
Date of Full-time Employment: _____	SSN: XXX-XX _____ (last 4 digits)

**SECTION B: TYPE OF DECLINATION:**

I AM DECLINING COVERAGE FOR:	Medical	Dental
<input type="checkbox"/> Myself	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Spouse or <input type="checkbox"/> Civil Union Partner	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Child(ren)		

**SECTION C REASON FOR DECLINING COVERAGE:**

I certify that I have been given the opportunity to participate in the group medical insurance plan offered by the Village of Park Forest and have declined to participate because I have coverage under:

- An individual plan       A government plan       COBRA or State Continuation  
 Spouse or civil union partner group coverage:  Single Coverage     Dependent Coverage

Spouse/civil union partner employed by: \_\_\_\_\_

Insured's name: \_\_\_\_\_ (please print)

Insurance Company name: \_\_\_\_\_

Insurance start date: \_\_\_\_\_

Medical: Insurance Company name \_\_\_\_\_ Group # \_\_\_\_\_

Dental: Insurance Company name \_\_\_\_\_ Group # \_\_\_\_\_

**IMPORTANT NOTICE OF SPECIAL ENROLLMENT**

If you are declining enrollment for yourself or your dependents (including your spouse or civil union partner) because of other medical insurance (including Medicaid or Children's Medical Insurance Program (CHIP) or group medical plan coverage, you may be able to enroll yourself and the dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents other coverage). However, you must request enrollment within 30 days after you or your dependents other coverage ends (other than Medicaid or CHIP) or if the employer stops contributing towards you or your dependent's other coverage and within 60 days after the loss of Medicaid or CHIP eligibility.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment and supply documentation within 30 days after the marriage, birth, adoption or placement for adoption or foster care.

PRINTED NAME OF EMPLOYEE: \_\_\_\_\_

Signature of Employee: \_\_\_\_\_ Date: \_\_\_\_\_