FIRE DEPARTMENT

MEDICAL INSURANCE WAIVER July 1, 2024- June 30, 2025

Employee's Name: _____

I request to waive my medical/dental insurance benefits as provided by the City of Pawtucket in return for the following payment:

Please check coverage(s) you are waiving:

Medical: Individual( )$1,000.00 Family:( )$3,000.00 ( ) No Stipend

Dental: Individual ( ) No Stipend Family: ( ) No Stipend

Article 11, Section 1. However, if an employee covered by this Agreement has a spouse who is also employed by the City (including the Pawtucket School Department or the Pawtucket Water Supply Board), and such employee has City-paid medical insurance by virtue of their spouse, and such employee elects not to be furnished with medical insurance pursuant to this section, then the City will reimburse said employee in accordance with the following schedule:
Subsequent to June 30, 2016 Family $0.00 Individual $0.00

The amount of waiver will be: _____

- This waiver is effective for twelve (12) months only must be renewed annually.
- If I need to reinstate medical coverage, I must notify the HR Department at least thirty (30) days in advance.
- I understand that the open enrollment period for all medical plans is June 1st to June 30th.

Waiver Payment will be included in employee's last paycheck in November.

I understand and agree that having received this medical reimbursement, if I subsequently enroll in medical or dental coverage with the City of Pawtucket before the end of the fiscal year, or if I shall no longer be employed by the City of Pawtucket before the end of the fiscal year, I shall repay to the City of Pawtucket on a pro-rated basis, monies which I have received for said waiver. I agree that this amount is payable to the City of Pawtucket within thirty (30) days of either coverage reinstatement or termination of employment or, at the option of the City, I agree that it may be deducted from my pay.

I certify that I have alternative medical insurance coverage and I am not covered by the Affordable Care Act at Healthsource RI or any other State or Federal agency.

Signature: _____

Date: _____