Town of Sutton

Health Insurance
Waiver of Participation

Name: _____ (PLEASE PRINT CLEARLY)

Coverage Effective Date:_____

I understand that my dependents and I are eligible for health insurance coverage and have an opportunity to purchase this coverage.

I also understand that the individual mandate from Health Care Reform requires that almost all individuals must obtain minimum essential health coverage or potentially pay a tax.

At this time, after careful review, I elect not to enroll in health insurance coverage.

Employee Signature: _____ Date:_____