TOWN OF RIVERHEAD
HEALTH INSURANCE BUY BACK FORM-POLICE DEC

STATE OF NEW YORK)
)ss
COUNTY OF SUFFOLK)

_____ being duly sworn, deposes and says:

1) I am a full-time police officer of the Town of Riverhead, currently covered by the employment contract between the Town of Riverhead and the Riverhead Chapter of the Police Benevolent Association, Inc. or the Superiors Officers Association, Inc.

2) That pursuant to the terms of this contract, I am entitled to Health Insurance. However, the terms also provide that I may waive coverage by the Town for a payment in any single year, payable to me annually during the months of June or December provided I have remained in an uncovered status for a period of twelve (12) consecutive months prior to the date of payment. I understand that no prorations will be given if I only want to waive coverage for part of the twelve month period, and no payment will be made to me whatsoever for such waiver. I hereby request my coverage to be waived and hereby execute this form as proof that I fully understand that I am no longer covered by the TOWN OF RIVERHEAD for the coverage that I have waived per the attached form. Further, I understand that this waiver for health insurance will remain in effect until I elect to have my insurance reinstated, even though this may be for more than one calendar year.

3) I understand and will adhere to Article 3 section 1(a) of the PBA contract or the SOA contract, whichever applies to me, which refers to my buy-out if two persons are currently receiving (or are eligible to receive) family health benefits through the Town.

4) That I understand that none of my doctor bills will be reimbursed through the plan and I must, therefore, look to other health insurance coverage provided by myself or through my spouse.

5) This plan meets requirements of Affordability and Minimum Value. In waiving coverage, I understand that I and/or my dependents may re-enroll only during the open enrollment period, unless I or they have suffered a qualifying event. I understand the effective date for coverage elected during the open enrollment period is January 1 of each calendar year; I further understand that coverage elected due to a qualifying event is the date of the event.

6) That I fully understand the contents of this affidavit; make this affidavit of my own free will without any pressure from anyone to sign this document.

Received, but not yet reviewed by personnel on _____
Date

MUST BE RETURNED TO TH E PERSONN EL DEPT. NO LATER THAN 2/28/25; NO LATE FORMS WILL BE ACCEPTED , NO EXCEPTIONS

2025 December Payment

Please check the applicable line indicating which buy-back option you are choosing:

HOSPITALIZATION:

1) Eligible for a family plan; waives all coverage. *If your spouse is employed by the Town and carries family coverage, please see #4 below

_____= $ 15,458.20

Reason for Waiving all Coverage - Please Check One:
[ ] Covered through spouse's employer [ ] Covered through a parent's employer
[ ] Under 65 Retiree covered by previous employer's insurance program
[ ] Other Please specify: _____

2) Eligible for a family plan; elects single coverage _____= $ 8,667.16

3) Eligible for Single coverage, waives all coverage _____=$ 6,791.04

*4) No longer eligible for a family plan pursuant to contract restrictions on dual family insurance when both spouses work for the Town; waives all coverage. _____= $ 6,791.04

***If you are no longer eligible for a family plan pursuant to contract restrictions on dual family insurance when both spouses work for the Town and you elect single coverage, no buyback will be owed per Article 3 section 1(a)**

BUY BACK AMOUNT = $_____

Sworn to before me this

_____ day of _____, 20__.

_____
NOTARY PUBLIC

_____
Signature

_____
Signature

_____
Date

Received, but not yet reviewed by personnel on _____
Date