PRINCE GEORGE'S COUNTY GOVERNMENT
BENEFITS AND PENSIONS DIVISION, 1400 McCORMICK DRIVE, SUITE 110, LARGO, MARYLAND 20774
BENEFITS@CO.PG.MD.US
PHONE: 301-883-6380 FAX: 301-883-6192

MEDICAL INSURANCE OPT-OUT FORM

FOR OFFICE USE ONLY
Transmitted By: _____
Entered: _____

EFFECTIVE DATE: _____

1. I understand that I have been offered the opportunity to enroll myself and my eligible dependents in Prince George's County Government (PGCG) sponsored medical plan(s) and that the medical plan(s) are considered to be minimum essential coverage (MEC) in accordance with the Affordable Care Act (Health Reform).

2. I understand that without an IRS-approved mid-year life change event (a Special Enrollment event), **if I decline coverage now**, I will not be permitted the opportunity to enroll myself or my eligible dependents in my employer's medical plan option(s) again until my employer's next annual open enrollment time (if I am benefits-eligible at that time).

3. I understand that there is additional compensation of $400 annually for medical and $200 annually (on a prorate basis) for prescription provided to me if I decline coverage. I understand that **I am only able to receive this additional compensation for declining coverage if I, and all members of my expected tax family (tax family refers to dependents on the employee's tax return), have or will have for the 2022 calendar year other minimum essential coverage through** another employer's group medical plan, Medicare, Medicaid, Tricare, or VA medical plan coverage.

4. I also understand that I am not eligible to receive this compensation if I or any member of my expected tax family is enrolled in individual market coverage, whether obtained through another Marketplace established under Health Reform, or outside of the Marketplaces established under Health Reform.

5. I also understand that PGCG will not make any payment to me if PGCG knows or has reason to know that I or any member of my expected tax family (tax family refers to dependents on the employee's tax return), does not have or will not have the required alternative coverage.

6. I agree to notify PGCG promptly if I or any member of my expected tax family (tax family refers to dependents on the employee's tax return), loses this alternative coverage, and I understand that compensation payments will be stopped at that time.

7. I also understand that I will be required to attest to this alternative coverage each plan year that I decline coverage under PGCG's group medical plan.

My signature below means that I have read and understand the above statements.

Print Name: _____ **Employee #:** _____

Signature: _____ **Date:** _____

Please keep a copy of this form for your records and return the original signed form with a copy of your medical card or proof of coverage *via mail, fax contact details above, or via email: Benefits@co.pg.md.us.*

Visit https://www.princegeorgescountymd.gov/3137/Benefits for benefit information and forms.

Received