

**ALLEGHENY COUNTY
HEALTH CARE BONUS WAIVER OPTION ELECTION FORM
CANCELLATION OF HEALTH CARE COVERAGE**

LAST NAME

FIRST NAME

M.I.

SOCIAL SECURITY NUMBER

DEPT. NUMBER

EMPLOYEE NUMBER

UNIT I.D. NUMBER

The Health Care Bonus Waiver Option has been explained to me and I fully understand the terms and conditions of this Health Care Bonus Waiver Option.

I understand that to receive payment under this Health Care Bonus Waiver Option, I must provide verification that I have health care coverage through another health care plan before health care coverage through Allegheny County is cancelled.

I further understand that I must cancel or waive **both** medical and dental coverage, if any, through Allegheny County to be eligible for this Health Care Bonus Waiver Option.

I hereby waive my rights to all County-provided group health coverage available to me.

Signature of Employee

Date

TO BE COMPLETED BY COMPANY'S PERSONNEL/BENEFITS DEPARTMENT

The above-noted individual is enrolled in the health plan provided by:

Company Name

Group Number

Effective Date of Coverage with this Company

He/She is a dependent of our employee:

Name of Individual Employed at other Company providing health care

Social Security Number

Signature of Company Official

Date

CANCELLATION OF COVERAGE WITH ALLEGHENY COUNTY EFFECTIVE _____

VERIFIED BY _____