**CITY OF BATH**
**HEALTH INSURANCE BUYBACK PROGRAM**
**Plan Year 2027**

**Requirements for Health Buy-Back Program:** This is a voluntary program, and you must re-apply annually. If you and/or others in your family choose medical insurance through another source, and you enroll in a less expensive level of City medical insurance coverage (or no City medical plan coverage), the City of Bath will give you 25% of its savings from your eligible premium. If you choose to decline MMEHT coverage, you are not eligible for their no-charge life insurance and must pay a premium if you choose to keep it. If you select an option below, you will receive the total annual payment in four quarterly installments, subject to State and Federal taxes. If you have questions about the program, please contact Erika Helgerson in the City Manager's Office, or Susan Hunt in the Finance Office.

**If you apply for the Domestic Partner Buyback, you must also submit the MMEHT Affidavit to show eligibility.

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**CIRCLE ONE OPTION BELOW. *If you elect "No Coverage," sign/date the Waiver Statement. ***

**Eligible for Family or Employee and Spouse/Domestic Partner** Level Coverage:** I am eligible for medical insurance coverage at the Family or Employee and Spouse/DP level, and I am enrolled in the coverage level circled below.

| | Annually | Quarterly |
|---|---|---|
| Employee with Children: | $1,696.46 | $424.12 |
| Employee Only: | $3,448.39 | $862.10 |
| No Coverage*: | $6,222.64 | $1,555.66 |

**Eligible for Employee with Children Level Coverage:** I am eligible for medical insurance coverage at the Employee with Children level, and I am enrolled in the coverage level circled below.

| | Annually | Quarterly |
|---|---|---|
| Employee Only: | $1,751.93 | $437.98 |
| No Coverage*: | $4,526.17 | $1,131.54 |

**Eligible for Employee Only Level Coverage:** I am eligible for medical insurance coverage at the Employee Only level, and I am not enrolled in City medical insurance. I am covered by a different insurance.

| | Annually | Quarterly |
|---|---|---|
| No Coverage*: | $2,774.25 | $693.56 |

Employee Name: _____ Date: _____/_____/_____

Signature: _____

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***WAIVER STATEMENT: If you are declining all City medical insurance, you must show proof of coverage under another plan every year to remain eligible for this program.**

"I have elected to not enroll in medical insurance coverage through the City's plan and I have coverage through the insurance company listed below. Attached is a copy of the coverage card. I will notify the Finance Office immediately if my coverage lapses at any time during the plan year."

Signature: _____ SS#:_____-____-_____ Date:_____/_____/_____

Insurance Company: _____ Policy#:_____

**Plan Year: 01/01/2027 - 12/31/2027**