Health Insurance Refusal Form

You are required to complete this form because you were offered health insurance coverage in one of the City of Springfield's Health Insurance Plan Offerings and have declined to participate.

By signing you acknowledge that in order to participate in the City's Plan at a later date, you must provide proof that you lost other coverage, have a qualifying life event, or wait until the next open enrollment.

If you are electing to join the plan because you lost your current coverage; you must provide proof of loss of that coverage and enroll in the City's Health Insurance Plan within 50 days of the loss of your prior coverage.

I acknowledge that Health Insurance Benefits have been offered to me and I hereby decline to enroll in the City's Health Insurance Plan at this time.

Print Name: _____

Social Security No.: _____

Department (work location): _____

Signature: _____

Date: _____

Please return this form to the City of Springfield's Benefit Department by email to orientation@springfieldcityhall.com or by fax to 413-787-6010.