Health Insurance Waiver Authorization Form
Marion County Law Enforcement Association (MCLEA) Only

Effective Date: _____

Last Name	First Name	Middle Initial
Phone Number	Department	Employee Number

Reason for completing form:

☐ New Hire

☐ Open Enrollment

☐ Eligibility or Status Change

This form, along with accompanying proof of other coverage, if applicable, must be received by Marion County Employee Benefits in accordance with newly eligible or open enrollment deadlines, or within 30 days of an eligibility or status change event.

☐ I wish to opt-out of all health insurance coverages offered to me by Marion County.

Proof of other health insurance must accompany this opt-out election form. I understand that by signing this form, I am making a binding election for the plan year. I am aware that there is no financial incentive when MCLEA employees waive coverage.

Irrevocable Election: I understand I cannot change or revoke this election except during an open enrollment period or if I have a change of status as outlined in the Marion County Benefits Plan Rules. Any election change must be requested within the open enrollment period or within 30 days of the qualifying event.

Employee Signature: _____ EE Number: _____ Date: _____

Return completed form and proof of other coverage to
Marion County Employee Benefits: MCEmployeeBenefits@co.marion.or.us