MACOMB COUNTY
Human Resources and Labor Relations Department
1 South Main Street, 6th Floor, Mount Clemens, MI 48043 ▪ Phone (586)469-5280 ▪ Fax (586)469-6974

INSURANCE WAIVER PROGRAM AND AFFIDAVIT

☐ Employee ☐ Retiree

Name: _____
Last Name, First Name

Last four of your Social Security Number: ###-##-_____

I elect to participate in the Insurance Waiver Program.

I understand that I have been given the opportunity to elect medical insurance coverage through Macomb County which I decline at this time for myself, my spouse and my dependents (if applicable).

I understand that my election to participate in the Insurance Waiver Program will continue until I elect otherwise or have an insurance status change.

I understand that if I wish to enroll in Macomb County's medical insurance, because of an insurance status change, I must complete the required paperwork and submit it to Human Resources and Labor Relations within 30 days of the qualified status change or loss of coverage.

I have read, understand and fully agree with the information stated above.

_____ _____
Signature Date

_____ _____
Witness Signature Date