



switchpoint™

## 2025 Health Insurance Opt-Out Contribution

To help offset the cost of a group health plan, Switchpoint Full-Time eligible employees that opt out of Switchpoint Health Insurance **MAY** be eligible for a post-tax Opt-Out Contribution. Qualifying full-time employees would receive a post-tax contribution of \$175 per paycheck.

To receive this Contribution, a full-time employee that opts out of Switchpoint Health Insurance **MUST** be enrolled in qualifying Group/Employer health coverage through a spouse/parent, meet the following criteria, and sign the disclosure below.

1. **Provide Proof of Health Coverage:** Proof of health coverage must be received by Human Resources within the employee's new-hire enrollment period or during open enrollment.
  - a. If Proof of Coverage is not received by the employee's insurance eligibility date, then the employee will forfeit this contribution until the next Open Enrollment period when they may re-apply.
  - b. The following qualify as "proof of coverage"
    - i. Medical insurance card showing current coverage
    - ii. Benefit print-out from medical insurance showing current coverage
    - iii. Proof of coverage must show that the Switchpoint employee is enrolled
2. **Switchpoint Employees that are enrolled as dependents** in another Switchpoint employee's health insurance are NOT eligible for the Opt-Out Contribution.
  - a. Any Full-Time eligible Switchpoint employee may enroll in health coverage during their new-hire window, during open enrollment, or qualifying life event.

I \_\_\_\_\_ acknowledge I have been offered the opportunity to enroll myself and eligible family members in Switchpoint's Group Health Plan.

I decline enrolling myself and eligible family members in Switchpoint Health coverage because:

☐ I have Group/Employer coverage through a ☐ SPOUSE ☐ PARENT ☐ Other \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_

- Policy/Group Number: \_\_\_\_\_ / \_\_\_\_\_
- Through (Employer/Group Name): \_\_\_\_\_

### **\*PLEASE ATTACH PROOF OF INSURANCE TO THIS WAIVER**

To the best of my knowledge, I have provided accurate and up-to-date information. I will not hold Switchpoint responsible or liable for any penalties, taxes, or fees incurred for receiving this Opt-Out Contribution.

Employee Name \_\_\_\_\_ Date \_\_\_\_\_

Employee Signature \_\_\_\_\_