Agreement to Decline (Opt-Out) Medical Coverage
Non-Represented and Eligible Represented Employees

HR-BEN-036

Section 1 - Information and Instructions

The purpose of this form is to decline MTA sponsored benefits coverage. Unless otherwise stated, the MTA Business Service Center (BSC) will assume that each year you would like to continue your opt-out agreement, and will never request this form again. If you wish to enroll in MTA Benefits coverage during any point of your tenure with the MTA, you will only be able to do so during the open enrollment period, or a qualifying life event.

Please email completed form to bscservice@mtabsc.org.or fax to 212-852-8700.

If you have any questions, please contact the Business Service Center (BSC) at 646-376-0123 or bscservice@mtabsc.org.

Section 2 - Employee Information

Print Name	Last		First		M.I. Suffix	BSC ID
Agency/Dept. (check one)	☐ BSC	☐ B&T	☐ CC	☐ HQ	☐ NYCT	Department
	☐ SIR	☐ LIRR	☐ MNR	☐ MTA Bus	☐ MABSTOA	
Street Address						
City					State	Zip Code
Phone (H)			Phone (W)			Email

Section 3 – Incentive Selection

*Select the option that will be applicable for the entire year of **20**____*

INITIAL YOUR SELECTION

☐ I am an employee who receives medical coverage through my spouse/domestic partner who is also employed by the Metropolitan Transportation Authority or another MTA agency, and I, therefore, decline health coverage. Incentive for this option is **$1,000 or $550**. Payment will occur after the end of the plan year.

☐ I am an employee without dependent(s) declining individual coverage. Incentive for this option is **$1,000 or $550**. Payment will occur after the end of the plan year.

☐ I am an employee with dependent(s) declining family coverage. Incentive for this option is **$3,000 or $1,100**. Payment will occur after the end of the plan year.

Note: If you have previously waived coverage or you do not currently have dependent coverage, you must provide documentation for dependents in order to opt out of family coverage. See the enrollment form for details.

Section 4 – Medical Coverage Information

*Provide the information relative to the medical plan that you will be enrolled in for the year **20**____*

Name of Insurance Company:	Plan Sponsor (Employer):
Name of Policyholder:	Relationship:

Section 5 – Medical Coverage Information

I understand that this election will be effective from January 1 through my tenure with the MTA, unless I am no longer allowed by law or as a result of a qualifying event or such other events as the Authority determines will permit a change or revocation of an election. I understand that the lump sum payment will be subject to all applicable federal, state and local taxes. I also understand that these monies will not be considered income for pension purposes and will not be included in any calculation therein.

THIS AGREEMENT IS SUBJECT TO THE TERMS OF THE EMPLOYER'S PLAN, AS AMENDED FROM TIME TO TIME IN EFFECT, SHALL BE GOVERNED BY AND CONSTRUED IN ACCORDANCE WITH APPLICABLE LAWS, SHALL TAKE EFFECT AS A SEALED INSTRUMENT UNDER APPLICABLE LAWS, AND REVOKES ANY PRIOR ELECTION AND COMPENSATION AGREEMENT RELATING TO SUCH PLAN. THE HEALTH BENEFITS WAIVER WILL BE ADMINISTERED AS PERMISSIBLE UNDER IRC SECTION 125.

Employee Signature	Date	SSN Last 4 Digits