SUFFOLK COUNTY DEPARTMENT OF CIVIL SERVICE/HUMAN RESOURCES
DIVISION OF EMPLOYEE SERVICES - EMPLOYEE BENEFITS UNIT

APPLICATION FOR WAIVER OF PREMIUM

When a waiver of health benefits contributions is requested because of total disability, the following information is required. Any expenses incurred solely for obtaining the attending physician's statement on this application are not a covered medical expenses. For further information, e-mail the Employee Benefits Unit at ebu@suffolkcountyny.gov or call (631) 853-4866.
Note: Review your Plan's Benefit Booklet to see if you may qualify for a waiver of premium.

Instructions:
1. **Part A** to be completed by the Enrollee.
2. **Part B and Part C** to be completed by the Employee Benefits Unit.
3. **Part D** to be completed by the attending physician who then mails form directly to the Employee Benefits Unit.

PART A (To be Completed by Enrollee) ***Please print or type***

Enrollee's Name (Print)	S.S.# (last four digits)	Enrollee's Date of Birth
Home Address (No. and Street) Apt. #	City State	Zip Code
PRESENTATION OF MATERIALLY FALSE INFORMATION IN SUPPORT OF AN INSURANCE APPLICATION OR CLAIM IS PROHIBITED BY ARTICLE 176 OF THE PENAL LAW. I hereby apply for a waiver of premium under the Employee Medical Health Plan of Suffolk County or one of the HMO's. If approved, this approval is contingent on the employee's continuing Leave Without Pay status throughout the waiver period. I understand that should my total disability end or I return to the payroll, be terminated, retire or resign during the waiver period this waiver will terminate and I may be responsible for the cost of continuing health plan coverage.		
Enrollee's Signature	Telephone No.	Date

PART B (To Be Completed by Employee Benefits Unit) ***Please print or type***

Effective Date of Leave	Enrollee's Health Benefits Coverage: ☐ Individual ☐ Family	Health Benefits Option
Department	Telephone Number	Social Security # XXX-XX-
Authorized Signature		**Date**

PART C (To Be Completed by Employee Benefits Unit) ***Please print or type***

☐ Approved	to	☐ Not approved
Date first disabled (Effective Date) (mm/dd/yy)	Disability through (mm/dd/yy)	
Signature		**Date**

Please have your physician complete the medical portion on the reverse side.

PERSONAL PRIVACY PROTECTION LAW NOTIFICATIONS

The information you provide on this application is requested for the principal purpose of enabling the County to process your request for a waiver of health benefits premium in the Employee Medical Health Plan or one of the HMO's. This information will be used in accordance with Section 96 (1) of the Personal Privacy Protection Law, particularly subdivision (b), (e), and (f). Failure to provide this information may result in the disapproval of an individual to participate in this program or a delay in the payment of benefits. This information will be maintained by the Employee Benefits Unit, S.C. Department of Civil Service/Human Resources, Division of Employee Services. If you need more information concerning the waiver of premium, please contact the Employee Benefits Unit via e-mail at ebu@suffolkcountyny.gov or via telephone at (631) 853-4866 between the hours of 9:00 a.m. and 5:00 p.m., Monday through Friday.

PART D (To Be Completed by Attending Physician) ***Please print or type***

Enrollee's Name	**Health Insurance ID Number**
Physician's Name	**Physician's Address**
Telephone Number (including area code)	

When did the disability first prevent the employee from performing his or her regular duties?	(mm/dd/yyyy)
Is the employee currently disabled?	☐ Yes ☐ No
On what date did you **FIRST** treat the employee for this disability?	(mm/dd/yyyy)
On what date did you **LAST** examine the employee?	(mm/dd/yyyy)
When do you estimate the employee will be able to resume his or her regular duties?	(mm/dd/yyyy)

Complete description of medical condition, including diagnosis, prognosis, current status and service being received and expected date of termination of total disability:

If more space is necessary, attach additional pages

PLEASE NOTE: Unless all questions are answered completely, a determination cannot be made.

Physician's Signature **Date**

Enrollee or attending physician mails the completed form to:

Employee Benefits Unit
Division of Employee Services
S.C. Department of Civil Service/Human Resources
P.O. Box 6100
Hauppauge, NY 11788-0099