



OFFICE OF THE SELECTMEN

2 Main Street, PO Box 960

Amherst, NH 03031

www.town.amherst.nh.us

Tel. (603) 673-6041 Fax (603) 673-6794

Email: bos@town.amherst.nh.us

HEALTH INSURANCE STIPEND POLICY

A Town employee eligible for group health insurance who is covered by his/her spouse's group health insurance through his/her employer (other than the Town), or has other existing health insurance, may elect to receive a taxable stipend equal to fifty percent (50%) of the Town's cost of the lowest eligible plan offered by the Town of Amherst, in lieu of carrying duplicate coverage through the Town.

Proof of health insurance coverage is required. A signed statement from his/her spouse's employer or insurance carrier must show: the name of the insurance carrier, the Town employee's name listed as a dependent or subscriber, the period of coverage, and/or the date of eligibility, and type of coverage (Family, 2 person, etc.) If by proof of coverage under another health insurance plan, the Town employee chooses not to participate in the Town's health insurance plan that employee will receive a taxable stipend each pay period.

A Health Insurance Stipend Agreement must be completed by the employee with proof of coverage by May 15th or within 30 days of employment, and approved by the Town Administrator to receive payment. The agreement must be renewed each year in which the employee is eligible for this benefit.

Purpose: This stipend is an incentive for employees to not carry duplicate health insurance coverage through the Town when coverage is already available to you. It is not a means to replace all health insurance coverage. An employee must have existing health insurance in order to qualify.

The employee must notify the Town's Benefit Administrator in writing within thirty (30) days if a qualifying event (such as a birth, death, loss of employment, or divorce, etc.) occurs where the Town employee is no longer eligible for coverage under his/her other plan. At that time, the employee and eligible dependent(s) will be enrolled in the Town's group health insurance plan effective the date of the qualifying event and the stipend will cease to be paid to the employee.

The employee shall hold the Town harmless of any error or omission on the employee's part for failure to notify the Town in writing within thirty (30) days of a qualifying event in which the employee should have been enrolled under the town's group health insurance plan.

Bob Heaton, Chairman

Libb Crocker, Vice Chair

Marilyn Peterman

Steve Desmarais

Jay Dinkel



OFFICE OF THE SELECTMEN

2 Main Street, PO Box 960

Amherst, NH 03031

www.town.amherst.nh.us

Tel. (603) 673-8041 Fax (603) 673-6794

Email: bos@town.amherst.nh.us

TOWN OF AMHERST, N.H. HEALTH INSURANCE STIPEND AGREEMENT

I, _____, am a Town of Amherst employee eligible for the Town's Group Health Insurance, and elect not to enroll in the Town's plan for the fiscal (July 1st to June 30th) year _____.

I understand and agree to the following (initial each of the following):

_____ I anticipate having health insurance coverage for the above fiscal year, under my spouse's plan through his/her (Non-Town of Amherst) employer _____.

_____ I am required to provide the Town of Amherst proof of health insurance coverage, with a signed statement from the health insurance provider showing:

The name of Insurance Carrier
My name listed as a dependent or subscriber
Period of Coverage and/or date of eligibility
Type of Coverage (Family, Two-Person, etc.)

_____ If, by proof of coverage under my other plan, I do not participate in the Town's health insurance plan for the duration of the above fiscal year, I will receive a taxable stipend each pay period.

_____ This stipend is an incentive not to carry duplicate health insurance through the Town of Amherst whereas I am eligible for insurance under my own or spouse's plan.

_____ If a qualifying event occurs where I am no longer eligible for coverage under my other plan, I must notify the Town of Amherst Town Administrator in writing within thirty (30) days, and enroll under the Town's group health insurance plan, at which time this stipend agreement becomes null and void.

_____ I shall hold the Town of Amherst harmless of any error or omission on my part for failure to notify the Town Administrator in writing within thirty (30) days of a qualifying event in which I should have been enrolled under the Town's group health insurance plan.

_____ This agreement will lapse at the end of the fiscal year shown above. Renewal is not automatic and must be applied for by May 15th each year, and requires the approval of the Town Administrator.



OFFICE OF THE SELECTMEN

2 Main Street, PO Box 960

Amherst, NH 03031

www.town.amherst.nh.us

Tel. (603) 673-6041 Fax (603) 673-6794

Email: bos@town.amherst.nh.us

Employee Signature

Date of Hire

Today's Date

Town Administrator Approval

Date

Effective: January 21, 2002

Revisions: