NASSAU COUNTY EMPLOYEE
VOLUNTARY
HEALTH BENEFIT BUYBACK PROGRAM
APPLICATION FORM

Employee's Name: _____ Social Security No. _____-____-_____

Employee's Department: _____ Telephone: Office _____

Home Address: _____ Home _____

_____

Name of Spouse: _____ Spouse's Social Security No. _____-____-_____

Alternate Insurance Carrier: _____
(Proof must be provided)

Alternate Form of Coverage Provided Through: _____Spouse's Coverage_____Other employment
_____Prior Employment _____Direct Purchase

Type of Coverage: ☐ Individual Coverage ☐ Family Coverage

I certify that my Dependents and I are sufficiently covered for health benefits under an alternate coverage and I exonerate the Union and the County of Nassau from any liability for coverage. The alternate coverage does not include an exclusion clause preventing spousal buy-back. If in the event the above coverage should cease for any reason, I will immediately reapply for coverage by completing an enrollment form and submitting it to my Department.

EMPLOYEE'S SIGNATURE: _____ DATE: _____

STATE OF NEW YORK)
) ss:
COUNTY OF NASSAU)

On this day of , before me personally came to me known and known to me to be the person described in and who executed the same.

_____
Notary Public

COUNTY / UNION AFFILIATION (If Any): _____

Reviewed By: _____
Human Resource Officer

Forwarded to Comptroller _____
Date