Michelle Lujan Grisham, Governor
Kari Armijo, Secretary
Alex Castillo Smith, Deputy Secretary
Kathy Slater Huff, Deputy Secretary
Kyra Ochoa, Deputy Secretary
Dana Flannery, Medicaid Director

Local Public Body Employees
PREMIUM ONLY PLAN (POP)
NOTICE OF WAIVER

I, ______________________________ , wish to “waive” participation in the Premium Only Plan (POP) for the benefits plan year of January 1 through December 31, 20______ .

I understand by signing this waiver, my benefits will be deducted from my pay as an after-tax deduction. I further understand that my enrollment into this program is on a yearly basis and will be up for renewal on January 1st of the coming new year and will not be automatically carried over.

______________________________ ______________________________
Employee Name (print) **Agency Name and Number**

______________________________ ______________________________
Employee Signature **Date**

Form must be submitted to your Human Resources or Payroll Contact for processing.

Late submission of the POP Waiver will not be granted.