Seattle Office of Labor Standards

SMC 14.28 Voluntary Ordinance (ORD) Waiver

Some employees may waive their rights to healthcare expenditures under the Improving Access to Medical Care for Hotel Employees, Seattle Municipal Code (SMC) 14.28. Employees who wish to waive should read this form thoroughly to determine if they are eligible to waive.

Employers and employees with questions about this form can contact the Office of Labor Standards (OLS) at 206-256-5297 or visit the OLS website at http://www.seattle.gov/laborstandards/ordinances/hotel-employee-protections.

Part A. INFORMATION FOR EMPLOYERS

Employers should review and complete this prior to providing the form to an employee.

To be valid, all waiver conditions required by SMC 14.28 and Seattle Human Rights Rule 190-220 must be met. This includes, but is not limited to:

- Only employees who have health coverage from another source may waive coverage.
- An employee may not be pressured to sign the waiver.
- An employer may not suggest or imply that the employee must sign.
- The waiver form must be completed fully.
- The waiver form may not be altered in any way.
- This form must be provided to the employee in their primary language. This form is available in other languages on the Office of Labor Standards website.

Employer's plan for satisfying the healthcare expenditure for: Employee First and Last Name

Y/N	Type of expenditure	Monthly amount
	Payment(s) towards employer-sponsored health insurance	
	Payment(s) towards health savings account	
	Payments towards health reimbursement account	
	Payment toward flexible spending account	
	Other: Specify	
	Ordinary income payments	

Employer Contact: *For employees with questions related to the healthcare expenditures*

Employer Name	
Employer Address	
Employer Contact Person	
Contact Email and Phone	

Employer and employee should keep a copy of this document.

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Part B. INFORMATION FOR EMPLOYEES ABOUT THEIR RIGHTS

Employees should read this carefully.

Seattle law requires this employer to make monthly healthcare expenditures to you or on your behalf. A healthcare expenditure is an amount of money paid by your employer to provide you with access to healthcare services. For example, your employer can:

- Make payments to enroll you in a health insurance program;
- Make payments into a health savings account or health reimbursement account for you; and/or
- Make ordinary income payments to you.

Your employer chooses which way(s) to meet their legal obligation. The amount that an employer pays varies depending on the size of your household. The current amounts are listed on the OLS website.

The law requires this employer to make healthcare expenditures **even if** you have health coverage from another source. But, your employer can request that you waive your right to receive these expenditures if you currently receive health coverage from another source. You do not have to agree.

If you sign, you are telling your employer that you have health coverage from another source and that it can stop making mandatory healthcare expenditures to you or on your behalf. The waiver is good for one year. An employer must obtain an updated form each year that you wish to waive your rights.

You can also revoke (cancel) a voluntary waiver during any period of annual open enrollment or due to an event that makes you eligible for health coverage by this employer. This cancellation must be in writing. Sample language that you can use is available on the OLS website.

EMPLOYEE VOLUNTARY WAIVER

Sign only if you wish to give up your rights.

By signing below, I certify under penalty of perjury under the laws of the State of Washington that the following are true:

- I read and understand the above information about my rights under the law.
- I receive affordable, high-quality health coverage from the other source I have identified below.
- I wish to give up my right to receive healthcare expenditures from this employer.
- I understand that this waiver is good for one year.
- I understand that I may cancel the waiver in writing.
- If I have questions, I may contact the employer contact person listed in Part A of this form.

Employee Name	First Last	I get insurance from:	Name of Source
Signature			
Date	MM/DD/YYYY	Location	City, State

Employer and employee should keep a copy of this document.

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