Waiver of Group Health Benefits – 2017

Employee Name (PRINT)

I acknowledge I was offered an employer sponsored group health plan that meets the Affordable Care Act's affordability and minimum value requirements but I choose not to participate in the medical plan.

For the plan year effective ***January 1, 2017 – December 31, 2017***, I am waiving MEDICAL coverage for:

☐ Myself

☐ Spouse/Domestic Partner

☐ Dependents(s):

I am waiving coverage due to:

☐ My preference not to have coverage

☐ Coverage under my spouse's/domestic partner's plan

☐ Other coverage

This other coverage is:

☐ Employer-sponsored Group Plan ☐ Individual policy ☐Medicare ☐ COBRA ☐TRICARE ☐ Medicaid

☐ Other _____

Special Enrollment Notice and Certification – *Please review and sign below if you wish to waive coverage*

By signing below, I certify that I have been given an opportunity to apply for coverage for myself and my eligible dependents, if any. I am declining enrollment as indicated above. I understand that, if I am declining enrollment for myself or my eligible dependents (including my spouse) because of other health insurance or group health plan coverage, I may be able to enroll myself and my eligible dependents in this plan if I lose, or my eligible dependents lose, eligibility for that other coverage (or if the employer stops contributing towards my or my eligible dependents' other coverage).

I understand that I must request enrollment no more than 30 days after the date the other health plan coverage ends (or after the employer stops contributing toward the other coverage). If I do not do so, I will not be able to enroll until my employer's next annual open enrollment period.

In addition, I understand that if I have a newly eligible dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my eligible dependent(s). However, I must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

I acknowledge I was offered an employer sponsored group health plan that meets the Affordable Care Act's affordability and minimum value requirements but I choose not to participate in the medical plan.

I understand that in order to request special enrollment or obtain more information, I should contact my group administrator.

Employee Signature **Date**

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