Waiver of Group Health Benefits

Company Name_____

Company Address_____

City_____ **State**_____ **Zip**_____

Employee Name _____

Employee Address_____

City_____ **State**_____ **Zip**_____

Tax Identification Number	Benefit Year	Social Security Number	Date of Birth

If Waiving on Behalf of Dependent(s), Please List:

Name	Social Security Number	Date of Birth	Other Type of Coverage

I am Waiving Coverage Due to:

- ☐ My Preference to Not Have Coverage
- ☐ Coverage Under my Spouse's/Domestic Partner's Plan
- ☐ Other Coverage

If Selecting Other Coverage, Coverage is:

- ☐ Spouse's Employer-sponsored Group Plan
- ☐ Parent's Employer-sponsored Group Plan
- ☐ Individual Policy (**No cash-in-lieu payments are available for Individual Market or Marketplace coverage**)
- ☐ Medicare
- ☐ COBRA
- ☐ TRICARE
- ☐ Medicaid

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 by waiving group coverage that I may not have another opportunity to enroll in coverage until the next open enrollment period. 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.

Special Enrollment Rights
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 understand that to request special enrollment or obtain more information, I should contact my group administrator.

Premium Tax Credit
I understand that I may not qualify for a premium tax credit through the Exchange, if this group health plan is deemed to meet affordability and minimum value requirements, regardless of whether I waived coverage. I also acknowledge that by failing to maintain minimum essential coverage, I may be liable for an individual shared responsibility payment.

Cash-in-lieu Payments
I understand that I am declining enrollment in employer-sponsored coverage for myself and my tax dependents for this benefit year. I also certify that I have other acceptable minimum essential coverage that is not individual market coverage, including Marketplace coverage, such as employer-sponsored coverage through a family member. I understand that by maintaining coverage through the Marketplace I will not be considered eligible to receive cash-in-lieu payments. I acknowledge that I may be deemed ineligible for cash-in-lieu payments if my employer has reason to believe that I do not have other acceptable minimum essential coverage.

I agree that by signing this document I have read and understood the information contained in this waiver along with the consequences that may stem from waiving this offer of group health benefits.

_____ _____
Employee Signature **Date**

_____ _____
Employer Signature **Date**