Magenic

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Waiver Form to Decline Health Coverage

Employee Name:	
Employee Date of Birth:	Employee's Social Security Number (last 4 digits):

I acknowledge that I have been offered coverage under Magenic's group plan with BlueCross BlueShield of MN, and I attest and confirm that I and my dependent(s) are declining coverage for the following reason:

☐ I am covered by TRICARE
☐ I am covered by Medicare
☐ I am covered by another group health plan through a spouse, domestic partner or parent:
- Employer Providing Health Care Services: _____
- Name of Insurance Provider: _____

☐ I am **not** covered by one of the group health options listed above

If you have checked any of the boxes above, please attach evidence of other coverage.
- Evidence may be a copy of the previous month's billing, insurance ID card, or similar proof.

If you are ***working out of the San Francisco, CA or MA office*** and you are waiving medical coverage, you will also need to fill out either the San Francisco, CA waiver form or the MA waiver form found on our intranet (Connect).

Employees are eligible to elect the Opt Out Cash benefit if they **(1)** waive the company offered medical, dental and vision benefits (must waive all three), **(2)** show proof of current group health insurance coverage, and **(3)** complete state specific waiver, if applicable. With this, eligible employees will receive a taxable cash benefit of $75.00 per pay period (total $150.00 per month).

Employees are **not** eligible to receive the Opt Out Cash benefit if:
- Waive only the company offered medical benefit (must waive all 3 to qualify)

or

- Waive the company offered medical, dental and vision benefits, but checked the "I am **not** covered by one of the group health options listed above" box

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I understand that by declining health coverage through Magenic Technologies, I cannot revoke or change this election during the plan year unless me or my dependents lose eligibility for this other coverage or have a qualifying event (i.e. change in family and/or job status) and request enrollment within 30 days after that event. To obtain more information, please contact payrollbenefits@magenic.com.

I understand that I and/or any of my dependents will be unable to obtain coverage under Magenic's group health plans until the next open enrollment period, unless I and/or my dependents qualify for enrollment under the aforementioned special enrollment rules.

Employee Signature:_____ Date:_____