Waiver of Group Health Benefits & Notice of Special Enrollment Rights

To voluntarily choose to waive Group Health Coverage, please complete the following:

Employee Name:

_____

Last First MI

For the plan year , I am waiving coverage for:

☐ Myself ☐ Spouse : _____

☐ Dependent(s) – Please list name(s): _____

_____

I am waiving coverage due to:

☐ My preference not to have coverage

☐ Coverage under my spouse's plan – name of carrier: _____

☐ Other coverage – name of carrier: _____

This other coverage is: ☐ Individual ☐ COBRA ☐ Medicare ☐ Medicaid

☐ TRICARE (formerly CHAMPUS) ☐ Employer-Sponsored Group Plan

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 foradoption.

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

Employees and dependents who lose eligibility under a Medicaid plan or CHIP and employees and dependents who become eligible for a premium assistance subsidy under Medicaid or CHIP must be given 60 days after the loss of coverage or determination of eligibility for assistance to request coverage under the group health plan

Since passage of the Affordable Care Act (ACA) in 2010, the delivery of healthcare services in America has been redefined by a steady flow of new benefits, requirements and regulatory guidelines. Implementation of the ACA occurred on January 1, 2014, at which time an important new delivery system – **Healthcare Exchanges**, also known as the **Health Insurance Marketplace,** was introduced. This marketplace is another vehicle available to you for purchasing health insurance. You are not required to purchase insurance coverage through the Marketplace, as we will continue to offer health coverage to all eligible employees.

The ACA's individual mandate requires most people to have health insurance or pay a penalty tax. The fee for not having medical coverage for 2016 is calculated 2 different ways – as a percentage of your household income, and per person. **You'll pay whichever is higher… as shown below:**

Percentage of income:

1. 2.5% of household income
2. **Maximum:** Total yearly premium for the national average price of a Bronze plan sold through the Marketplace

Per person:

1. $695 per adult
2. $347.50 per child under 18
3. **Maximum:** $2,085

_____ _____

Employee Signature Date

Please return to Trupti Kapoor at trupti.k@sstech.us .

Note: This form does not cancel coverage. If you wish to cancel existing coverage for the 2016 plan year, you must submit a written request to Trupti Kapoor. Please specify all types of coverage that you wish to cancel.