

Starcorp, LLC
1/1/2017 – 12/31/2017 Benefit Plan Year
Health Benefits Waiver Form



Employee Name (last, first): _____
Date of Employment: _____
Date of Birth: _____
SS#: _____
Street Address: _____
City: _____
State/Zip: _____
Email Address: _____
Cell Phone: _____

I have been given the opportunity to enroll in the Starcorp, LLC group health insurance plan.

I am declining to enroll for the reason shown below:

- ☐ I am covered by my spouse's/domestic partner's group coverage
Carrier Name and Member ID _____
- ☐ Enrolled in another Insurance Carrier Plan (individual or group)
Carrier Name and Member ID _____
- ☐ Covered by Medicare
- ☐ Covered by TRICARE or CHAMPVA
- ☐ Other (Please explain in detail) _____

Special Enrollment Notice and Important Information

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 affordable ACA compliant coverage for myself and my eligible dependents, if any. I am declining enrollment as indicated above and have read and understand the special enrollment information below.

Special Enrollments

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may, in the future, be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after coverage was terminated as a result of loss of eligibility for the coverage or termination of employer contribution (60 days for special enrollees who have lost their Medicaid or State Children's Health Insurance Program coverage). In addition, if your current coverage changes or you have a life-changing event, such as your marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the qualifying event. Coverage will become effective on the date of the qualifying event.

Pre-existing Conditions

In accordance with the Affordable Care Act, plans with an effective date on or after January 1, 2014, are prohibited from excluding or limiting pre-existing conditions from coverage. This means that plans must cover eligible expenses for pre-existing conditions beginning with the effective date of the plan.

Annual Open Enrollment Period

Eligible employees may enroll themselves and their eligible dependents during the annual open enrollment period, which is the month prior to the start of the new plan year. Currently our open enrollment period is the month of December for a January 1st effective date.

Complete and email to healthcare.mih@gmail.com

Signature of Employee

Date Signed