MA HEALTH CARE COVERAGE WAIVER FORM

Company Name _____ **Date** _____/_____/_____

Employee Name _____

On behalf of myself and my eligible dependents (if any), I waive the option to enroll in health insurance offered at this time by or through my employer for the following reason:

Waiving Group Health Coverage *(Please select one of the following)*

☐ I am covered under another group plan as a spouse or dependent

☐ I am covered by MassHealth, Medicare, Veterans Program or a subsidized plan through the Exchange

☐ I am covered under another group plan sponsored by a second employer

☐ I am covered under another carrier's plan sponsored by this employer

☐ I am covered under a non-subsidized plan through the Exchange

☐ I am covered through a non-group, individual or private health care plan not offered through my employer

☐ I do not wish to participate in health care benefits at this time (I am declining health insurance entirely)

If you are waiving coverage because you have coverage elsewhere, please provide the following information:

Carrier Name: _____ Subscriber Name: _____

Is the plan through the Exchange? ☐ Yes ☐ No If yes, is this plan subsidized through the Exchange? ☐ Yes ☐ No

I affirm that the information I have provided on this form is true and complete to the best of my knowledge and belief. I understand that The Company may either refuse to renew coverage or terminate coverage, retroactive to the effective date, for any material misinformation (including omissions) contained in this form.

I understand that any person choosing to enroll at a time other than during my employer's open enrollment must meet The Company's requirements for eligibility and the special enrollment rights summarized below.

Employee Signature _____

Print Name _____ **Date** _____/_____/_____

Notice of Special Enrollment Rights

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 health plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of 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 marriage, birth, adoption, or placement for adoption.

Special enrollment rights may also apply if you lose coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for state premium assistance under Medicaid or CHIP. An employee or Dependent who loses coverage under Medicaid or CHIP as a result of the loss of Medicaid or CHIP eligibility may be able to enroll in this Plan, if enrollment is requested within 60 days after Medicaid or CHIP coverage ends. An employee or Dependent who becomes eligible for group health plan premium assistance under Medicaid or CHIP may be able to enroll in this Plan if enrollment is requested within 60 days after the employee or Dependent is determined to be eligible for such premium assistance.