Health Insurance Coverage Waiver Form
Fowlerville Community Schools

_____ **January 1, 2024**

Employee Name *(Please Print)* Plan Effective Date

I am waiving coverage for:
□ Myself
□ Spouse
□ Dependent(s) – Please list names:_____

I am waiving due to:
□ My preference not to have coverage
□ Coverage under my spouse's plan
□ Coverage under my parent's plan
□ Coverage under individual plan **(No cash-in-lieu payments are available for Marketplace coverage)**
□ Other coverage This other coverage is: □ COBRA □ Medicare □ TRICARE □ Medicaid

Please review and sign below if you wish to waive coverage

By signing below, I certify 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 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.

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 for adoption.

I understand that to request this type of enrollment or to obtain more information, I should contact Human Resources.

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 subject to a penalty.

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 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 understand the information contained in this waiver along with the consequences that may stem from waiving this offer of group health benefits.

Return this form to Human Resource after 10 business days of receipt or before the Open Enrollment deadline.

_____
Date Received

_____ _____
Signature Date