**Health Insurance Waiver 2021**

**Fowlerville Community Schools**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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