_____

(Name of Employer)

WAIVER OF MEDICAL COVERAGE

You may decline health coverage offered by the Employer,_____ (Name of Employer). This is called a waiver of coverage. If you waive coverage for yourself, you may not cover dependents under the Employer's health plan.

Note that after 2013, if you decline coverage considered affordable and minimum essential under the Patient Protection and Affordable Care Act ("ACA"), you will not qualify for government credits and subsidies to purchase individual health insurance on the Marketplace.

The decision to waive coverage has consequences for you. For example:

- You should be aware of the individual responsibility requirement that took effect in 2014 under the ACA. If you refuse the offer of the Employer's health coverage and do not obtain coverage on your own, you will be subject to a penalty.

- Unless you sign a waiver stating that you are covered under another plan, such as a spouse's plan, Medicaid, or Medicare, you cannot enroll in the Employer's health plan until the next open enrollment. However, if you are covered under another plan, but that coverage is lost, you can enroll in your Employer's health plan immediately. There's a time limit for enrolling after the other coverage is lost: you must request to enroll in your plan within 30 days of losing the other coverage.

- If you gain a new dependent through birth, adoption or marriage, you may enroll yourself, the new dependent, and the entire family at that time, but you must do so within 30 days of gaining the new dependent. If you miss the 30-day enrollment deadline, you must wait until open enrollment.

I acknowledge that the Employer has offered me affordable minimum essential coverage, as defined under the ACA, for the period from _____ to _____ (coverage period). I have read the above and I understand the consequences of my waiver of coverage.

_____ I am waiving medical coverage due to _____ (reason for waiver).

_____ I am NOT waiving medical coverage.

WAIVER OF OPTIONAL COVERAGES
(mark X at each coverage waived)

- **Dental** _____
- **Vision** _____
- **Life (employer sponsored)** _____
- **Life (voluntary)** _____
- **Short Term Disability** _____
- **Long Term Disability** _____

_____	_____	_____
Name of Employee	**Signature of Employee**	**Date**

As a representative of the Employer, I received this Waiver of Coverage from the above employee on _____ (Date).

_____

Signature of the Employer Representative