_______________________________ Health/Prescription Drug Benefits Waiver Form

Under the Affordable Care Act's **Employer Shared Responsibility** ("Pay or Play") mandate, we are subject to a potential IRS penalty if we do not offer all full-time employees and their eligible dependents "minimum essential coverage." If you elect <u>not to enroll</u> in the minimum essential coverage you are eligible for and being offered, you <u>MUST</u> complete the **Your Election** section below and return a completed and signed original not later than _______________.

Name: _________________________________ SSN: _____________________

PLAN YEAR: From ________________ To _______________

EFFECTIVE DATE OF COVERAGE OFFERED: _____________________

Your Coverage Options
{Option 1 Description}
{Option 2 Description}
{Option 3 Description}

Your Election

1. I am waiving enrollment in the above coverage options for the following individuals (check all that apply):

Myself

My Spouse/Domestic Partner (please list name) ____

My Eligible Dependents (please list names) ____

____

2. The reason I am waiving coverage is (check one):

Personal preference

Covered under my spouse's Employer-sponsored Group plan (insert employer's name):

____

Covered under another plan (please check applicable box below):

Individual Medicare Medicaid Other (please specify)_____________________________

By signing below, I certify that I have been given an opportunity to enroll in coverage for myself and my eligible dependents, if any. I am voluntarily waiving enrollment in the coverage(s) indicated in the "Your Coverage Options" section above. I understand that I cannot change my election until the next Open Enrollment period unless I have a change in family, employment or coverage status (a "qualifying event"). I further understand that, if I do experience a qualifying event, I may be able to enroll myself and/or my eligible dependent(s) before the next Open Enrollment. In that event, I understand that I must request a special enrollment from my employer within <u>30 days</u> of that qualifying event.

____

Employee Signature Printed Name Date Signed