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| --- | --- |
| Waiver of Group Health Benefits | |
| Employee Name   |  | | --- | |  | | |
| Job Title   |  | | --- | |  | | |
| Employee Number (ID, Social Security, etc.)   |  | | --- | |  | | |
|  | |
| For the plan year effective       I am waiving coverage for:  Myself  Spouse/Domestic Partner  Dependents(s):  If selecting Dependent(s), please list their name(s):   |  | | --- | |  |   I am waiving coverage due to:  My preference not to have coverage  Coverage under my spouse’s/domestic partner’s plan  Other coverage  This other coverage is:  Employer-sponsored Group Plan  Individual policy Medicare  COBRA TRICARE  Medicaid | |
| **Special Enrollment Notice and Certification** *– Please review and sign below if you wish to waive coverage*  By signing below,   * I certify that 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 understand that I cannot enroll in coverage until the next open enrollment period unless I experience a change-in status event. * If I experience a change-in status event, I understand that I must request enrollment no more than 30 days after the event. If I do not do so, I will not be able to enroll until the next open enrollment period. I understand that in order to request special enrollment or obtain more information, I should contact my group administrator. * I understand that the individual mandate was effective January 1, 2014 and that most individuals are required to have health insurance or pay a tax. It is my responsibility to seek professional tax advice when making the decision to waive coverage. ­­­­­­­­­­­­­­­­­­­The Diocese of Erie is not responsible for any taxes that I may incur. | |
| Employee Signature   |  | | --- | |  | | Date   |  | | --- | |  | |