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| Waiver of Group Health Benefits |
| Employee Name

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| Job Title

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| Employee Number (ID, Social Security, etc.)

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| 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):

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I am waiving coverage due to:[ ]  My preference not to have coverage[ ]  Coverage under my spouse’s/domestic partner’s plan[ ]  Other coverageThis 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.
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| Employee Signature

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 | Date

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