EMPLOYEE BENEFIT SERVICES

WAIVER/CASH IN LIEU
OF GROUP HEALTH BENEFITS

Note To SET SEG Clients:

This waiver is provided as a starting point for plans looking to document offers of health coverage to ACA-eligible employees. It is intended to be used to supplement your compliance program which should include consultation with your benefits counsel.

Please note that several sections (which are in red font for easy recognition) require your attention as they may not apply to your specific health plan.

EMPLOYEE BENEFIT SERVICES

SET SEG

WAIVER/CASH IN LIEU OF GROUP HEALTH BENEFITS

Important Information: Completion of the Waiver/Cash In Lieu of Medical form affirms your waiver of medical benefits for the current year. ***Provided you <u>are eligible</u> for cash in lieu of benefits***, this form will also serve as an election to your entitled payout. ***If you <u>are not eligible</u> for cash in lieu of benefits***, this form will only serve as a waiver of coverage.

EMPLOYER NAME | EMPLOYER ADDRESS

CITY | STATE | ZIP

EMPLOYEE NAME | EMPLOYEE ADDRESS

CITY | STATE | ZIP

SOCIAL SECURITY NUMBER	BENEFIT YEAR	BIRTHDATE MM/DD/YY

If Waiving on Behalf of Dependent(s), Please List:

NAME: (FIRST, LAST)	SOCIAL SECURITY NO.	BIRTHDATE MM/DD/YY	OTHER TYPE OF COVERAGE

I AM WAIVING COVERAGE DUE TO:

- ❍ My Preference to Not Have Coverage
- ❍ Coverage Under my Spouse's/Domestic Partner's Plan
- ❍ Other Coverage

IF SELECTING OTHER COVERAGE, COVERAGE IS:

- ❍ Spouse's Employer-sponsored Group Plan
- ❍ Parent's Employer-sponsored Group Plan
- ❍ Individual Policy: *No cash-in-lieu payments are available for Individual Market or Marketplace coverage)*
- ❍ Medicare
- ❍ COBRA
- ❍ TRICARE
- ❍ Medicaid
- ❍ Retirement Plan

Continue on next page

WAIVER/CASH IN LIEU OF GROUP HEALTH BENEFITS CONTINUED...

SPECIAL ENROLLMENT NOTICE AND CERTIFICATION: *Please review and sign below if you wish to waive coverage.*

ACKNOWLEDGEMENT OF WAIVER

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 by waiving group coverage that 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.

SPECIAL ENROLLMENT RIGHTS

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 special enrollment or obtain more information, I should contact my group administrator.

PREMIUM TAX CREDIT

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 liable for an individual shared responsibility payment.

CASH-IN-LIEU PAYMENTS

Completion of the Waiver of Group Health Benefits form confirms your waiver of medical and other applicable benefits for the current year. ***If you are not eligible for cash-in-lieu of benefits***, this form will only serve as a waiver of coverage.

If you are eligible for cash-in-lieu of benefits, this form also allows you to elect cash-in-lieu. If you decide to elect cash-in-lieu, please review the following language:

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 individual market coverage, including 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 understood the information contained in this waiver along with the consequences that may stem from waiving this offer of group health benefits.

Please complete and return this waiver form to [insert email address] or fax to [insert fax number]. To receive cash-in-lieu by waiving coverage, you must complete and submit this form by the end of Open Enrollment or within 30 days of your qualifying event.

EMPLOYEE SIGNATURE DATE