Waiver of Offer of Town of Webster Group Health Coverage

Employee Name: _____

By submitting this form, I acknowledge that I have been provided an opportunity to review and participate in a Town of Webster health insurance plan.

Reason for Waiving Coverage - Please Check One: **PLEASE PROVIDE COPY OF INSURANCE CARD**

☐ Covered through spouse's employer

Subscriber Name _____ Insurance Provider _____

☐ Covered through a parent's employer

Subscriber Name _____ Insurance Provider _____

☐ Under 65 Retiree covered by previous employer's insurance program

Subscriber Name _____ Insurance Provider _____

☐ Other Please specify: _____

Please note that the Town of Webster believes that the health insurance that has been offered to you satisfies both the affordability test and the minimum value test under the Affordable Care Act (the "Act"). This means that it is unlikely that you will be eligible for any subsidies or cost sharing reductions if you decline enrollment and instead obtain coverage through the health insurance exchange. Additionally, please remember that if you fail to obtain health insurance coverage you may be subject to a penalty under the Act's "Individual Mandate." Your declination here is proof that the Town of Webster offered appropriate coverage and that you are aware that declination could have tax implications. If you have any questions, please refer to the *"MANDATORY NOTICE TO EMPLOYEES ON PPACA AND HEALTH INSURANCE EXCHANGES"* or contact Human Resources/Payroll.

CASH IN LIEU OF HEALTH INSURANCE COVERAGE BENEFIT: $4000 a year *for eligible employees who could elect 2-Person or family coverage only.*

Cash in lieu payment is taxable and is paid biweekly (Not included as wages for NYS Retirement purposes)

Opt-out payments are only available with proof that employee has coverage that is through another employer, and is not through the state-based exchange.

In waiving coverage, I understand that I and/or my dependents may enroll under this plan in the future only as a result of certain qualifying conditions. For example:

- For a "qualifying event" as defined by the health insurance provider
- Within 30 days of involuntary loss of other group coverage
- At the time of my employer's open enrollment

Employee Signature: _____ Date: _____