

Health Insurance Waiver Form (B-5Wb)

OPEN ENROLLMENT

Employee Name: _____ **RCUH Employee ID#:** _____

Instructions: Provide the completed, signed form to RCUH and retain a copy for yourself.

In compliance with the Patient Protection Affordable Care Act (ACA), you are required to complete this form on or before May 15, 2019 (the end of RCUH's 2019 Open Enrollment Period) if you have decided to CANCEL or WAIVE health care coverage with RCUH. Employees who are currently waiving health benefits at this time must submit this form to RCUH Human Resources as an agreement that he/she is still opting to waive health coverage. Individuals can obtain coverage in many ways, including by participating in RCUH's medical plans, purchasing insurance in the Federal Health Insurance Marketplace (HealthCare.gov), or by obtaining government health insurance such as Medicare Part A, Medicare Advantage plans, or Medicaid. More information about the Individual Shared Responsibility Payment can be obtained from the Internal Revenue Service's website: (<http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision>)

I have cancelled or waived coverage from RCUH's medical plan because:

I (*and if applicable, my eligible dependents*) prefer not to have coverage. I am declining health insurance entirely.

I (*and if applicable, my eligible dependents*) have coverage with another party (i.e., parent, spouse, domestic partner, civil union partner, or my own coverage purchased directly from a health insurance carrier).

I (*and if applicable, my eligible dependents*) have or will have coverage through the Federal Health Insurance Marketplace (HealthCare.gov).

I (*and if applicable, my eligible dependents*) have coverage such as Medicare, Medicaid, TRICARE, COBRA, Veterans Program, or other coverage recognized by the Secretary of Health and Human Services as minimum essential coverage.

By signing this waiver form, I am acknowledging the following:

- *I understand that RCUH has given me an opportunity to enroll in RCUH's Medical Plan for my eligible beneficiaries and myself but I am voluntarily declining enrollment as indicated above.*
- *I understand that by declining RCUH's Medical Plan at this time, I can only enroll in the future during RCUH's Open Enrollment Period or due to a Qualifying Event as defined by RCUH's Policy 3.520 RCUH Health Plans.*
- *I further understand that providing inaccurate information or falsifying the information contained in this form may result in disciplinary action including and up to termination of employment.*
- *I understand that I and (if applicable) eligible dependents will be ineligible for the Premium Tax Credit (PTC), since medical coverage was offered through RCUH (employer-sponsored coverage).*

Employee Signature: _____ **Date:** _____

Deadline to Submit Form: May 15, 2019

Submit via email: rcuh_benefits@rcuh.com or Fax: 808-956-5022