RCUH Research Corporation of the University of Hawaiʻi

FY 2020 - 2021

RCUH Health Insurance Waiver Form (B-5W)

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), 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. As a condition of employment or continued employment, an employee deemed eligible for the RCUH medical plan must elect or waive coverage with the RCUH. The RCUH reserves the right to deny an employee's continued employment for non-compliance of our election/waiver of medical coverage requirement. 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:** ____________________

RCUH will only accept WET SIGNATURES

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