RCUH Research Corporation of the University of Hawai'i *'Ahahuina Noi'i O Ke Kulanui O Hawai'i*

Employee Name: _____

RCUH Health Waiver Form (B5W)

(for any employee offered medical insurance through RCUH: Regular status employees 50% FTE or greater or Non-Recruited employees offered health insurance under the ACA – non-recruited 75% FTE or greater, and other ACA coverage for Plan Year: July 1, 2023 – June 30, 2024)

Current Employees: Do not use this form. Please submit eWaive via RCUH Employee Self Service via eUpload Section.
New Hires: Please submit form to rcuh_employment@rcuh.com

In compliance with the Patient Protection Affordable Care Act (ACA) and as an RCUH condition of employment, I am required to complete this form within two weeks of offer. 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.

SECTION I: Employee Waive

☑ **I am WAIVING coverage. Reason for Waive (Choose one option):**

- ☐ I am covered by a Federally established health insurance or prepaid health care plan, such as Medicare, Medicaid or medical care benefits provided for military dependents and military retirees and their dependents.
- ☐ I am covered as a dependent (e.g. spouse, child, etc.) under a qualified health care plan.
- ☐ I am a recipient of public assistance or covered by a State-legislated health care plan governing medical assistance (e.g. MedQuest).
- ☐ I am a follower of a religious group who depends upon prayer or other spiritual means for healing.

SECTION II: Employee Certification

While a signature (manual or electronic) is preferred, if form is submitted via Employee Self Service eUpload feature, the electronic submittal may serve as employee approval and certification of this form's content.

By signing this waiver form, I am acknowledging:
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 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:** _____

Questions about this offer? Contact RCUH Employee Benefits: Email: rcuh_benefits@rcuh.com