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

**Employee Name:** _____

**RCUH ID:** _____

RESET Form

# RCUH ACA Health Enrollment/Waiver Form (B-5A)

(for employees offered health insurance under the ACA only – non-recruited 75% FTE or greater, and other ACA coverage for Plan Year: July 1, 2024 – June 30, 2025)

**Current Employees: Upload form and supporting documentation to 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: Waive or Enroll – Please check one option.

☐ **WAIVE: I am waiving coverage because:**

- ◯ I prefer not to have coverage (I am declining health insurance entirely).
- ◯ I am covered as a dependent under a qualified health plan.
- ◯ I am covered by a Federally established health insurance plan (e.g., Medicare, Medicaid)
- ◯ A recipient of public assistance or covered by a state-legislated health care plan (e.g., MedQuest).
- ◯ A follower of a religious group who depends upon prayer or other spiritual means for healing.

☐ **ENROLL: I choose to enroll in RCUH ACA Health Insurance for:**

**Choose Tier:**

- ☐ Employee
- ☐ 2-Party
- ☐ Family (3+)

**Choose Location of Residency:**

- ☐ Hawai`i (enroll in Kaiser HMO Standard - Plan A)
- ☐ Outside Hawai`i (enroll in HMSA Comprehensive Medical Basic)

Click here for monthly premium rates.

**Enrolling Dependents:** *ACA defines dependents as: employee's (1) Biological or (2) Adopted child through the end of the month the individual reaches 26 years of age.* **PROOF OF RELATIONSHIP DOCUMENTATION IS REQUIRED** when adding a dependent (i.e., Birth Certificate, etc.) and subject to RCUH review. Complete the below information if selecting **2-Party or Family** coverage.

| ADD/ REMOVE | NAME (Last, First) | Date of Birth | Relationship | Gender |
|---|---|---|---|---|
| | | | | |
| | | | | |

## SECTION II: Employee Certification

*If enrolling, I authorize RCUH to set my effective dates of coverage and to deduct monthly employee contributions for each benefit plan from my salary. I understand my rights for continuation of health coverage under COBRA and am responsible to inform my dependents covered under my health insurance of their rights. I will contact RCUH HR if electing post-tax deduction.*

*If waiving, I understand that RCUH has given me an opportunity to enroll in RCUH's Medical Plan for my eligible beneficiaries and myself, and if I am voluntarily declining enrollment as indicated above, 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). Information provided on this form is true and complete to the best of my knowledge.*

**Employee Signature:** _____ **Date:** _____

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