MEDICAL BENEFIT WAIVER

Employee's Name: _____ Date: _____

Employee's ID or Last 4 digits of SS#: _____

Employee Acknowledgement

This form acknowledges that I have been offered, and have elected to voluntarily waive, coverage under THE TOWN OF CLINTON/CLINTON PUBLIC SCHOOL DISCTICT'S medical insurance plan.

I acknowledge that I fully understand the implications of waiving medical coverage and recognize that I will not have another opportunity to enroll until the annual company open enrolment period, unless I experience a qualifying event as defined by the company's health plan documents.

I understand that if I am declining enrollment for myself or my dependents (including my spouse) because of other medical coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that I request enrollment within 30 days after my other coverage ends. In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependents, provided that I request enrollment within 30 days after marriage, birth, adoption, or placement for adoption.

I further acknowledge my understanding that if I do not have medical coverage through another source, I may be exposed to a potential tax penalty under the Affordable Care Act for failing to have medical coverage.

Please select one: I am ☐ or I am not ☐ covered under another group health program as a spouse or a dependent.

If waiving coverage due to being covered under another group health plan, please include the other group's employer name: _____ and the subscriber name: _____

Employee's Signature: _____ **Date:** _____

For office use only: Approved ☐ Denied ☐:

Reviewer Signature: _____ Date: _____