Family Home Health NETWORK

INSURANCE WAIVER

Select Location Name: **Family Home Health Services, Inc.**

Today's Date:_____
Date [DD/MM/YYYY]

Print Name: _____

Social Security Number: _____ **Hire Date**: _____
Date [DD/MM/YYYY]

Having met the eligibility requirements, you are being offered the opportunity to enroll in medical, dental and vision coverage plan. You have the right to decline or waive coverage. If you do waive coverage for yourself, you may not cover dependents under the Employer's medical, dental and vision plan through the Plan year.

Note that if you waive coverage considered affordable and minimum essential under the Patient Protection and Affordable Care Act (ACA), you may not qualify for government credits and subsidies to purchase individual health insurance on the Marketplace.

- If you waive coverage, you cannot enroll in ***Family's*** medical, dental and vision plan until the next open enrollment, unless you experience a qualified change in status. Examples include if you are covered under another plan but that coverage is lost, or to add a new dependent through birth, adoption, or marriage. However, you must request to enroll in your plan within 30 days of the qualified change in status. If you miss the 30-day enrollment deadline, you must wait until open enrollment. For further details please review Summary Plan Description Document.

I acknowledge that the Employer has offered me affordable minimum essential coverage, as defined under the ACA, for the Plan Year that ends on **December 31, 2021**.

Medical Waiver ☐ **Dental Waiver** ☐ **Vision Waiver** ☐

Health & Dental Waiver Reason – [check reason]							
1	Individual Coverage		☐	5	VA Eligibility		☐
2	Spousal Coverage		☐	7	COBRA		☐
3	Other Coverage		☐	8	Too Costly		☐
4	Medicaid		☐	9	No Other Coverage		☐
5	Medicare		☐	10	Other Reason		☐

I have read the above and I understand the consequences of my waiver of coverage.

_____ _____
Signature of Employee Date [DD/MM/YYYY]