Waiver of Employer Sponsored Health Coverage for Benefits Eligible Staff Member

ARCHDIOCESE OF NEW ORLEANS

Having met the eligibility requirements, you are being offered the opportunity to enroll in health coverage offered by The Archdiocese of New Orleans. You have the right to decline/waive coverage. If you do waive coverage for yourself, you may not cover dependents under the Employer's health plan.

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

Please initial next to each statement:

_____ I understand that if I am waiving/declining coverage because I am covered under another plan, such as a spouse's plan, Medicaid, or Medicare, and that coverage is lost, I can enroll in my Employer's health plan immediately. I understand that this must be done within 30 days.

_____ I understand that if I gain a new dependent through birth, adoption or marriage, I may enroll myself, the new dependent, and the entire family at that time, but I must do so within 30 days of gaining the new dependent. If I miss the 30-day enrollment deadline, I understand that I must then wait until the next open enrollment period.

_____ I understand that it is my responsibility to request special enrollment forms from my Site Administrator and submit them within 30 days of the date of the life event.

_____ I acknowledge that my Employer has offered me the opportunity to enroll myself and my eligible dependents in Employer Sponsored Health Insurance for the plan year effective / / , and I am choosing to waive/decline/terminate the coverage.

I am waiving/terminating coverage due to:

- ☐ Coverage under my spouse's plan
- ☐ Alternate coverage
- ☐ Other reason: _____

If you have different coverage, please indicate the type:

- ☐ Individual
- ☐ COBRA
- ☐ Medicare
- ☐ TRICARE
- ☐ Medicaid
- ☐ Employer-Sponsored Group Plan

**If you are choosing to terminate your health coverage during the plan year, please indicate the effective date: / /*

Name of Staff Member (Printed) **Signature of Staff Member** **Date**

As a representative of The Archdiocese of New Orleans, I have received this Waiver of Coverage from the above staff member.

Name of Site Administrator (Printed) **Signature of Site Administrator** **Date**

Location