Waiver of Group Health Benefits & Notice of Special Enrollment Rights

Ability360 – Plan Year January 1, 2017 – December 31, 2017

Please complete the following and fax to 602-528-3422 or email to benefits@ability360.org.

Employee Name: _____ _____ _____
(Last) (First) (MI)

Employee Number: _____/_____/_____
Social Security or Employee ID # (Date of Birth)

I am waiving coverage for:

☐ Myself	☐ Medical	☐ Dental
☐ Spouse	☐ Medical	☐ Dental
☐ Dependents/Children	☐ Medical	☐ Dental

I am waiving coverage due to:

- ☐ I do not want coverage
- ☐ I have coverage through my spouse. Name of insurance company: _____
- ☐ I have other coverage. Name of insurance company: _____
  - ☐ **This other coverage is:** ☐ Individual ☐ Employer Group Plan
  - ☐ **My coverage is with:**
    - ☐ AHCCCS / Medicaid ☐ Healthcare Marketplace ☐ TRICARE
    - ☐ Medicare ☐ COBRA

Special Enrollment Notice and Certification – ***Please review and sign below if you wish to waive coverage***

By signing below, I certify that I have been given an opportunity to apply for coverage for myself and my eligible dependents, if any. I am declining enrollment as indicated above. I understand that I am declining enrollment for myself or my eligible dependents (including my spouse).

I may be able to enroll myself and my eligible dependents in this plan if I lose, or my eligible dependents lose, eligibility for other coverage (or if the employer stops contributing towards my or my eligible dependents' other coverage). **I understand that I must request enrollment no more than 30 days after the date of any other loss of coverage** (or after the employer stops contributing toward the other coverage). If I do not do so, I will not be able to enroll until my employer's next annual open enrollment period.

In addition, I understand that if I have a newly eligible dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my eligible dependent(s). However, **I must request enrollment within 30 days of the marriage, birth, adoption, or placement for adoption.**

I understand by declining coverage I may be subject to an Individual Mandate Penalty and may not have the ability to receive a subsidy on the Health Insurance Marketplace. I certify that I, and my dependents, have been offered coverage that is affordable, accessible and meets the minimum value as defined by the IRS. I also understand that I will not have the opportunity to enroll in this coverage until Ability360's next open enrollment for an effective date of 01/01/2018, unless I have a qualifying event as identified by my employer.

I understand that this waiver will be in effect until and unless I either enroll in coverage or revoke the waiver in writing.

For more information, I should contact Human Resources. 1-844-274-7284 / email: benefits@ability360.org

_____ _____ _____
PRINTED NAME SIGNATURE DATE

** SAMPLE **

Waiver of Group Health Benefits & Notice of Special Enrollment Rights

Ability360 – Plan Year January 1, 2017 – December 31, 2017

Please complete the following and fax to 602-528-3422 or email to benefits@ability360.org.

Employee Name: SMITH (Last) SUZIE (First) S. (MI)

Employee Number: 123-45-6789 (Social Security or Employee ID #) 03/17/1984 (Date of Birth)

I am waiving coverage for:

☒ Myself	☒ Medical	☒ Dental	> check all coverage you are waiving!
☒ Spouse	☒ Medical	☒ Dental	
☒ Dependents/Children	☒ Medical	☒ Dental	

I am waiving coverage due to:

- ☐ I do not want coverage
- ☒ I have coverage through my spouse. Name of insurance company: BCBS
- ☐ I have other coverage. Name of insurance company: _____
  - ☐ **This other coverage is:** ☐ Individual ☐ Employer Group Plan
  - ☐ **My coverage is with:**
    - ☐ AHCCCS / Medicaid ☐ Healthcare Marketplace ☐ TRICARE
    - ☐ Medicare ☐ COBRA

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In addition, I understand that if I have a newly eligible dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my eligible dependent(s). However, **I must request enrollment within 30 days of the marriage, birth, adoption, or placement for adoption.**

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For more information, I should contact Human Resources. 1-844-274-7284 / email: benefits@ability360.org

Suzie Smith	S Smith	11/08/2016
PRINTED NAME	SIGNATURE	DATE