



**Roswell Park Comprehensive Cancer Center
WAIVER OF COVERAGE**

Employee Name: _____ EMP ID _____

I am currently eligible for Roswell Park's health insurance coverage through the NYS Health Insurance Program (NYSHIP). I acknowledge that I elected to waive enrollment in this benefit. I understand that by waiving coverage for myself that my dependents cannot enroll in Roswell Park's health plan.

I am waiving coverage due to:

<input type="checkbox"/> My preference is not to have coverage
<input type="checkbox"/> Coverage under my spouse's/domestic partner's plan Company Name: _____ Name of carrier: _____
<input type="checkbox"/> Other coverage Name of carrier: _____ This other coverage is: <input type="checkbox"/> Individual <input type="checkbox"/> COBRA <input type="checkbox"/> Medicare <input type="checkbox"/> TRICARE(formerly CHAMPUS) <input type="checkbox"/> Medicaid <input type="checkbox"/> Employer-Sponsored Group Plan

I understand that by waiving coverage considered affordable and minimum essential under the Patient Protection and Affordable Care Act (ACA), I will not qualify for government credits and subsidies available to purchase individual health insurance on the marketplace.

In addition, I accept the decision to waive coverage has consequences such as:

- If I waive Roswell Park/NYSHIP coverage and do not obtain coverage on my own, I will be subject to a penalty responsibility requirement of the ACA.
- I must satisfy a waiting period of ten (10) weeks to enroll in Roswell Park's health coverage through NYSHIP unless I experience a qualified change in status.

I acknowledge that Roswell Park has offered me affordable minimum essential coverage as defined under the ACA. I have elected not to enroll in health insurance coverage at this time.

Signature of Employee

Date

Signature of Employee Benefits Representative

Date