WAIVER OF HEALTH INSURANCE COVERAGE

Employee Name:_____

- ☐ I am an employee of Roswell Park Cancer Institute
- ☐ I am an employee of Health Research, Inc. – Roswell Park Division

I am currently eligible for 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 RPCI's health plan.

I am waiving coverage due to:

☐ My preference is not to have coverage

☐ Coverage under my spouse's/domestic partner's plan

Company Name:_____
Name of carrier:_____

☐ Other coverage

Name of carrier:_____

This other coverage is: ☐Individual ☐COBRA ☐Medicare ☐TRICARE(formerly CHAMPUS)

☐Medicaid ☐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 subsides 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 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 health coverage through NYSHIP unless I experience a qualified change in status.

I acknowledge that I have been offered 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**