Hardeman County Board of Education

WAIVER OF COVERAGE

You may decline health coverage offered by the Employer, Hardeman County Board of Education. This is called a waiver of coverage. If you waive coverage for yourself, you may not cover dependents under the Employer's health plan.

Note that after 2013, if you decline 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.

The decision to waive coverage has consequences for you. For example:

- You should be aware of the individual responsibility requirement taking effect in 2014 under the ACA. If you refuse the offer of the Employer's health coverage and do not obtain coverage on your own, you will be subject to a penalty.

- Unless you sign a waiver stating that they are covered under another plan, such as a spouse's plan, Medicaid, or Medicare, you cannot enroll in the Employer's health plan until the next open enrollment. However, if you are covered under another plan, but that coverage is lost, you may be eligible to enroll in your Employer's health plan due to a Special Enrollment Qualifying Event; along with required documentation. There's a time limit for enrolling after the other coverage is lost: you must enroll in the State plan within 60 days of losing the other coverage.

- If you gain a new dependent through birth, adoption or marriage, you may enroll yourself, the new dependent, and the entire family at that time, but you must do so within 60 days of gaining the new dependent. If you miss the 60-day enrollment deadline, you must wait until open enrollment.

I acknowledge that the Employer has offered me affordable minimum essential coverage, as defined under the ACA, for the period from January 1, 2017 to December 31, 2017. I have read the above and I understand the consequences of my waiver of coverage.

_____ _____ _____

Name of Employee Signature of Employee Date

Social Security #_____, Date of Birth _____

As a representative of the Employer, I received this Waiver of Coverage from the

above employee on _____ (Date).

_____

Signature of the Employer Representative