

WAIVER OF COVERAGE

EMPLOYEE NAME: _____

HIRE DATE: _____

COMPANY: _____

ENROLLMENT DATE: _____

Coverage(s) declined for:

- | | | | |
|----------|---------------------------------|--|-------------------------------------|
| MEDICAL: | <input type="checkbox"/> Myself | <input type="checkbox"/> Spouse/Domestic Partner | <input type="checkbox"/> Child(ren) |
| DENTAL: | <input type="checkbox"/> Myself | <input type="checkbox"/> Spouse/Domestic Partner | <input type="checkbox"/> Child(ren) |
| VISION: | <input type="checkbox"/> Myself | <input type="checkbox"/> Spouse/Domestic Partner | <input type="checkbox"/> Child(ren) |

Reason for declining coverage: (please check one)

- Covered under another employer health benefit plan (e.g., through spouse, domestic partner)
Carrier Name: _____ Group #: _____ (attach copy of ID card)
- Covered under an individual plan through a separate health carrier
Carrier Name: _____ (attach copy of ID card)
- Other: _____

- | | |
|---|---|
| <input type="checkbox"/> FLEXIBLE SPENDING ACCOUNT (FSA) - HEALTH | <input type="checkbox"/> FLEXIBLE SPENDING ACCOUNT (FSA) - TRANSPORTATION/PARKING |
| <input type="checkbox"/> FLEXIBLE SPENDING ACCOUNT (FSA) - DEPENDENT CARE | <input type="checkbox"/> AFLAC VOLUNTARY OPTIONS |
| <input type="checkbox"/> 401(K) SAVINGS & RETIREMENT PLAN | <input type="checkbox"/> COLONIAL LIFE VOLUNTARY OPTION |

_____ My initials acknowledge I have read the following paragraphs:

I have been notified that I, and any dependents that I may have, are eligible to enroll in any MMC sponsored group health plan coverage. I now decline to enroll in the MMC health plan(s) as indicated above. I am aware that my *next opportunity to enroll will be at the next Open Enrollment period*, unless I experience a Qualifying Event. If I experience a *Qualifying Event*, such as acquiring a new dependent as the result of marriage, birth, adoption or placement for adoption, I acknowledge that I, and any dependents that I may have, may request enrollment in any of MMC's group health plans by applying for that coverage within 30 days of the marriage, birth, adoption, or placement for adoption. If I have indicated above that the reason for declining coverage for myself and/or my dependent(s) is coverage under another health benefit plan, I acknowledge that if these individuals involuntarily lose coverage under the other employer's health benefit plan, I must request enrollment for them in MMC's group health plan *within 30 days*.

I am aware if I elect to enroll onto Covered California and my employer offers affordable health insurance coverage that meets the minimum-value standard defined by the Affordable Care Act (ACA), I will not be eligible for premium assistance or cost-sharing reductions.

Starting in 2014, under the Affordable Care Act, the individual shared responsibility provision calls for each individual to have minimum essential health coverage, or make a payment when filing his or her federal income tax return. Under the new rules, individuals choosing not to carry insurance are subject to a penalty. **The provision applies to individuals of all ages. As of now, for plan year 2018 penalties are \$695 per adult and \$347.50 per child under 18, or the greater of \$2,085 per family or 2.5% of household income.** The adult or married couple who can claim a child or another individual as a dependent for federal income tax purposes is responsible for making the payment if the dependent does not have coverage or an exemption.

X _____
Employee Signature

Date