KHEO
A Keenan Solution

2019 HEALTH COVERAGE WAIVER FORM

Return Completed Forms to: MMC Benefits Department via email: **Benefits@MMChr.com**, or Fax: **310-360-5100**, Phone: **800-899-6624**

PLEASE PRINT LEGIBLY. **Effective Date: 01/01/2019**

EMPLOYEE INFORMATION		
Employee Name (Last, First)	Phone Number	Employer

☐ I elect to decline medical coverage effective 1/1/2019– 12/31/2019 (if checked, select one of the reasons below). I understand that I have been offered employer coverage that meets the federal minimum essential requirements, but have elected not to enroll. I also understand that if I waive coverage, I cannot enroll until the next Open Enrollment, except in the case of a qualifying family status change event or loss of other group coverage for myself or my dependents*.

Select one of the following reasons. You will need to complete a new waiver form every year you waive.

☐ I have coverage under another group health plan.

Name of Other Plan / Group No: _____

☐ I am not covered under another group health plan, but do not choose to enroll at this time. I understand I am not eligible for the credit to waive coverage. (You may be subject to a tax penalty under the Affordable Care Act if you do not have health insurance coverage. Visit www.healthcare.gov for more information.)

*If you are declining enrollment for yourself or your dependents (including your spouse or Registered Domestic Partner) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after the other coverage ends.

In addition, if you have a new dependent as a result of marriage, registration of Domestic Partnership, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents provided that you request enrollment within 30 days after the qualifying family status change event.

ACKNOWLEDGEMENT	
I hereby certify that all the information shown above is true and correct to the best of my knowledge. I certify that the information I provided on this form and at all times during coverage about my family status and my dependents' eligibility for benefits under the benefit plan is accurate and that the Plan reserves the right to rescind coverage in the event of fraud or a material misrepresentation, and such rescission is effective on the date of such fraud or misrepresentation.	
Employee Signature	**Date**