

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*.

Effective January 1st, 2019 "ACA" eliminates the individual mandate penalties. Beginning in 2019 and thereafter, the government will no longer attempt to collect the individual mandate penalties if an individual or family does not obtain healthcare coverage. The elimination of the penalties does not technically remove the requirement to obtain healthcare coverage, only the penalty.

X _____
Employee Signature

Date