Voluntary Waiver of Health Insurance Benefits

1. It has been explained to me, that as an eligible employee, I am entitled to participate in the Diocese of Gary Health Care Insurance Plan.

2. I understand that if I participate in the plan, I would contribute only ten dollars ($10.00) each month for my coverage and any cost for dependent coverage if applicable. My employer will pay the remaining costs for my own participation in the plan.

3. I realize that in waiving participation in the plan, I am also waiving any claim to contributions, which would have been made, on my behalf for health insurance coverage.

4. I understand that periods of service during which I do not participate in the plan will not count toward "service credit" if I elect to enter the plan at a future date. And, that eligibility for health insurance coverage at retirement is based on years of continuous coverage, not years of continuous employment.

5. I have been informed that a condition of my election not to participate in the plan is proof that I am covered by another health insurance plan, other than the Diocese of Gary Health Care Plan.

6. I hereby acknowledge the receipt of the summary Health Insurance Portability and Accountability Act of 1996 (HIPAA) provided separately.

> IMPORTANT NOTICE TO LATE ENROLLEES: If you do not enroll within 31 days after becoming eligible, you will be considered a late Enrollee and may need to provide evidence of insurability to Anthem.

Please be advised that I freely choose **not** to participate in the Diocese of Gary Health Care Plan. I state that I have health care coverage in the plan named below:

Name of your insurance plan:

* ____

***If you are currently enrolled in an Affordable Care Act Marketplace medical plan, please contact the Human Resources department.**

Policy/certificate holder's name: ____

Please mark one:

☐ I also waive the term life insurance coverage. I understand that by waiving insurance coverage I cannot enroll until the 2019/2020 open enrollment period with an effective date of July 1, 2019 or unless I have a change in status. A change in status needs to be reported to the Human Resources department within 31 days of the date of the change.

☐ I wish to enroll in the term life insurance coverage, and have attached a life insurance beneficiary form. I understand that one dollar a month will be deducted from my payroll check.

Employee Signature ______________________________ Date ________________

Printed employee name ____

Employer (School, Parish or Institution) ____________________________________