POST FALLS SCHOOL DISTRICT WAIVER OF HEALTH COVERAGE

Employee's Name: _____ Date: _____

Employee's ID or Last 4 digits of SS#: _____

Employee Acknowledgement

This form acknowledges that I have been offered the opportunity to purchase health coverage from Kaiser Permanente Options, Inc. for myself and my dependents through my employer, and that I have elected to voluntarily waive this opportunity.

I acknowledge that I fully understand the implications of waiving medical coverage and recognize that I will not have another opportunity to enroll until the annual open enrollment period unless I experience a qualifying event as defined by the company's health plan documents.

I understand that if I am declining enrollment for myself or my dependents (including my spouse) because of other medical coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that I request enrollment within 60 days after my other coverage ends. In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependents, provided that I request enrollment within 60 days after marriage, birth, adoption, or placement for adoption.

I further acknowledge my understanding that if I do not have medical coverage through another source, I may be exposed to a potential tax penalty under the Affordable Care Act for failing to have medical coverage.

Please select one: I am ■ I am not ☐ covered under another group health program.

If waiving coverage due to being covered under another health plan, please include the following:

Insurance company name: _____Policy number: _____

Through: (employer or organization name) _____

Subscriber name: _____

Employee's Signature: _____ Date: _____

For office use only: Recorded ☐

Reviewer: _____ Date: _____