

**ATTESTATION OF ENROLLMENT
IN A NON-MCSIG EMPLOYER GROUP HEALTH PLAN**

Employee Name: _____

Work Phone: _____

Work Location: _____

Email: _____

This form applies to individuals who participate in the MCSIG CompleteCare and who waive coverage in the MCSIG Health Plan.

Employees, spouse/domestic partners and eligible dependents who are waiving coverage in the MCSIG Health Plan certify that:

-- MCSIG has offered me and/or my spouse/domestic partner and/or my eligible dependents a group health plan that does not consist solely of "excepted benefits" under the Affordable Care Act of 2010 ("ACA").

-- I and/or my spouse/domestic partner and/or my eligible dependents are enrolled in Alternate Coverage (such as my spouse/domestic partner's employer) that does not consist solely of "excepted benefits" under the ACA (such as limited-scope dental or vision coverage), nor does it consist solely of a "health reimbursement arrangement" (reimbursement of health care expenses up to a dollar limit).

-- I understand that by enrolling in the MCSIG CompleteCare, I am waiving participation for the MCSIG CompleteCare participants in the MCSIG Health Plan for my covered MCSIG CompleteCare enrollees as follows:

_____	_____
Name	Name
_____	_____
Name	Name

Attach a separate sheet if space is needed for additional participants

For confirmation that the Alternate Coverage meets the IRS's definition of minimum value and does not consist solely of an HRA, please contact the benefits coordinator at the other employer.

I further certify that my Alternate Coverage is not:

- High Deductible Health Plan (HDHP) **with** active contributions to a health savings account (HSA); however, as long as your spouse/domestic partner is not enrolled in the MCSIG CompleteCare, your spouse/domestic partner may contribute to an HSA and use the HSA funds. The HSA funds CANNOT be used for medical expenses for members enrolled in the MCSIG CompleteCare. All members may use the HSA funds for dental and/or vision as long as those expenses are not covered by the MCSIG CompleteCare.
- Medicare, Tricare or Medicaid
- Health Insurance Coverage made available thru the Affordable Care Act
- Individual policy
- Limited Benefit Health Plans
- You are NOT eligible if your Alternate Coverage is through another MCSIG employee

Employee Signature

Date

Spouse/domestic partner's Signature ONLY IF ELIGIBLE FOR COMPLETECARE

Date

For more information, please contact Catilize Health @ 877-872-4232

**PLEASE COMPLETE THIS FORM AND SEND TO LISA SIERRA, ELIGIBILITY & BENEFITS SPECIALIST
FAX, EMAIL OR MAIL:
MCSIG
76 Stephanie Drive
Salinas, CA 93901
Lsierra@mcsig.com
Fax 831-755-0172**