NORTH MASON SCHOOL DISTRICT NO. 403
MEDICAL WAIVER FORM School Year 2017-18

EMPLOYEE: _____ **SSN:** _____

I have been given the opportunity to enroll myself and my eligible dependents in the medical plans sponsored by my employer.

I understand that if I request health care coverage under this plan at a later date for myself or my dependents, coverage will be denied except:

1. during the annual open enrollment period specified in my employer's Group Medical coverage contract; or
2. as specified in the Health Insurance Portability and Accountability Act of 1996:
   * by special enrollment within 30 days after involuntarily loss of coverage; or
   * by special enrollment for both myself and my dependent(s) within 60 days after a dependent is added to my family through marriage, birth, adoption or placement by the courts.

EMPLOYEE WAIVER

I chose to waive coverage for myself for the reason(s) indicated below:

- ☐ Covered by another employer-sponsored Group Medical Plan.
  Group Medical Plan: _____
- ☐ Receive medical benefits from the U.S. Government through active or retired military medical coverage.
- ☐ Covered by Medicare.
- ☐ Other (please specify) _____

If I incur an IRS penalty due to my waiver of coverage, my employer is not responsible for any portion of such penalty since the company's coverage that was offered meets the government's requirement of affordability and minimal essential coverage. I also understand that because I waive such coverage and take a subsidy through the state exchange, I may be required to pay it back when I file my annual tax return. **Initial_____**

DEPENDENT WAIVER

I chose to waive coverage for my

☐ Child(ren) ☐ Spouse ☐ I have no dependents.

_____ _____

Employee Signature **Date**

Please submit this form to the Payroll Department.