Waiver of Group Health Plan Coverage

Company Name ActOne Government Solutions	Jobsite Locaton	Date of Hire
Employee Name (Last, First, M.I.)	Social Security Number	Date of Birth
Home Address		Phone Number
City	State	Zip Code

As a Full Time employee of ActOne Government Solutions, you are automatically enrolled in "Employee Only" coverage under the Aetna MedPremier Major Medical Health Plan. If you are currently covered under another Employer-Sponsored Major Medical Group Health Plan (for example, a spouse's health insurance), plan to maintain this coverage for the duration of the plan year, and wish to waive your coverage as an employee of **ActOne Government Solutions, you must submit this completed Benefit Election Waiver and proof of other coverage during the deadline to waive coverage below**. Should an event occur that prevents the continued participation in another Employer-Sponsored Major Medical Group Health Plan, and it is a qualifying life event (QLE), you will again be eligible to enroll in the ActOne Government Solutions Aetna MedPremier Major Medical Health Plan.

The following coverage types do not qualify to waive ActOne Government Solutions Aetna MedPremier Major Medical Health Plan coverage: Medicare; Medicaid; Veterans Administration (VA); Indian Health Services (IHS); individual plans (non-Employer Sponsored plans), including individual Qualified Health Plans purchased through a state or federal Affordable Care Act Exchange or Marketplace. **For more information, refer to 32 C.F.R. §199 and 42 U.S.C. §1395y(b)(3).**

Proof of other coverage is required. Please make a copy of the front and back of your current insurance identification card and attach the copy to this form for verification purposes. Your name must be visible on the card. If your name is not visible on the card, provide a letter, on the company's letterhead, from the insurance provider confirming that you are covered by the plan.

Please review, initial, and sign to waive coverage

For the plan year effective ____/____/_____, I am waiving coverage under the ActOne Government Solutions Aetna MedPremier Major Medical Health Plan, because I have active coverage under another Employer-Sponsored Major Medical Group Health Plan and plan to maintain that coverage for the duration of the plan year. Should I fail to maintain other Employer-Sponsored Major Medical Group Health Plan coverage, and I do not experience a qualifying life event (QLE), I will not be given another opportunity to enroll in this plan until a subsequent open enrollment period or qualifying life event (QLE).	**Initial**
I understand that if I do not submit the completed Benefit Election Waiver and the required supporting documentation within the timeframe indicated above, I will not be allowed to waive coverage, and I will not be given another opportunity to waive this plan until a subsequent open enrollment period or until I experience a qualifying life event (QLE).	**Initial**
I understand that choosing to waive employer-sponsored group health plan coverage may lead to disqualification for, loss of, or repayment of any tax credits or subsidies used to purchase an individual Qualified Health Plan through a state or federal Exchange/Marketplace.	**Initial**
I understand that by choosing not to participate in the Aetna MedPremier Major Medical Health Plan, I am waiving coverage under the plan available to me through ActOne Government Solutions. I understand that in order to waive coverage, my supporting documentation, for active Group Health coverage, must fulfill the requirements stated above. I also understand that I am making a binding election with respect to my benefits and that I will not have an opportunity to enroll in the plan unless I experience a qualifying life event.	**Initial**
I have read or had read to me the completed waiver form. I represent that all statements and answers made on or attached to this waiver form are true to the best of my knowledge and belief.	**Initial**

☐ **Because I am waiving the ActOne Government Solutions Aetna MedPremier Major Medical Health Plan, I would like my fringe dollars to instead be paid in the form of a Retirement Contribution.**

Employee Signature	Date

Please submit form by:	• Mail: **Boon Administrative Services, Inc. 6300 Bridgepoint Pkwy, Bldg. 3, Suite 200 Austin, TX 78730** • Fax: **512 339 6662 Attn: Government Enrollment** • Email: **enrollment@theboongroup.com**
Deadline to Waive Coverage:	**Open Enrollment** • Forms must be submitted during the open enrollment period. **New Hire Employees** • Forms must be submitted **within 30 days of your date of hire**.